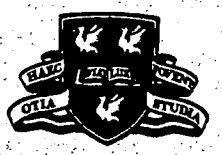

THE UNIVERSITY
of LIVERPOOL

THE Institute of Human Ageing

CONCEPTS OF GOOD PRACTICE IN RESIDENTIAL & NURSING HOMES FOR ELDERLY PEOPLE

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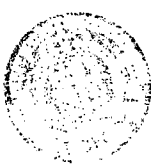

CONCEPTS OF GOOD PRACTICE IN RESIDENTIAL & NURSING HOMES FOR ELDERLY PEOPLE

CONTENTS

THE UNIVERSITY *of* LIVERPOOL

The Institute of Human Ageing

AGEING AND AGEISM

OBJECTIVES OF UNIT

This unit has the following aims:

- To help students get a better understanding of **old age**;
- To show that old age is not just about physical changes to the body, but about other factors, such as **people's attitudes** and **ageism**;
- To see how **ageism** can affect the services we provide to older people.

THE AGEING POPULATION

Nowadays, you hear a lot about the **ageing of the population**. You may have heard that there are many more old people than there used to be. Here are some basic figures to start with:

- In 1901 there were less than 2 million people aged 65 years or over living in Britain. By 1981, this had grown to over 8 million.
- In 1901 about 5 per cent of the population was aged over 65. By 1981 this had grown to 15 per cent.
- In 1981, there were just over half a million people aged 85 years or older. By the turn of the century, this will have doubled to well over 1 million.

HOW OLD IS *"OLD"*?

But what do we mean when we talk about the *"elderly"*? The first question we need to think about is **how old is *"old"***? We often think of old age as starting when a person is in their sixties, around the time when a person retires. When we see statistics about the elderly population, these usually refer to people aged 65 and over. But just think about this:

- Do we all become **old** overnight on our 65th birthday?
- Are 65 year-olds old in the same way as people in their 80's or 90's?
- Do some people seem a lot younger than their years, while others seem old before their time?

To say exactly what we mean by the *"elderly"* isn't as easy as it might seem at first. When middle age ends and old age begins is not clear-cut. Old age is also a matter of how you feel inside. Many people would be insulted if you called them "old", just because they were in their 60's, 70's or 80's.

WHAT IS OLD AGE?

So instead of looking at a person's age in years, it is perhaps better to look at the way they have grown older. To do this, we need to look at the changes that occur to a person in old age.

What are the physical changes that come with old age?

We generally think of ageing in terms of **physical changes to the body**. This is not a single process, but is a result of a number of complex bodily changes, such as the gradual wearing out of certain body parts or the building up of toxic substances in the body. These changes are accompanied by physical changes such grey hair and wrinkles. There are a number of bodily changes that come with old age:

- bones become brittle and break more easily
- many of the major joints no longer work properly due to conditions such as arthritis, which restrict mobility and cause pain
- muscle cells are lost, leading to weakness
- the senses are affected by age: poor hearing and sight can be major problems and loss of smell and taste can reduce enjoyment of food
- female fertility ends with menopause
- some body mechanisms may no longer work properly, such as body temperature, blood pressure and the bladder

The effects of bodily changes should not be seen in isolation from each other. For example, brittle bones, painful joints and muscle weakness will result in changes in a person's posture and the way they walk. This may cause problems of falling, when accompanied by changes in a person's balance and reaction time.

Is old age a disease?

Not all of these changes in the body should not be seen as illnesses or diseases. Rather, they

are part and parcel of getting older and are only a problem when they become serious or cause disability. While the body undergoes many changes, these are often gradual and can be compensated for by the older person.

We often think of older people as unhealthy, sick and dependent. In fact most older people are fit and active, even those who are in their 80's. We will be looking at the issue of disability in a later training session.

What mental changes are linked to old age?

This last point is especially important when we look at the mental changes that come with old age. It was once thought that senility was inevitable in old age and that everyone who reached advanced years would lose their ability to remember things and to communicate.

It is now known that these severe changes are a result of diseases such as Alzheimer's Disease and that this only affects a small proportion of elderly people. About 5% of people over the age of 65 suffer from dementia, although this figure does increase with age. (We will be looking at Dementia in more depth in a later unit).

However, there are some mental changes that accompany old age. Many older people find it more difficult to remember things, like names or telephone numbers. They may also find it more difficult to do a lot of things at once, like driving a car, where you have to steer, change gear, watch the traffic and so on. These mental changes may annoy a person, but they are usually only minor problems and may only be noticeable when a person has to think very quickly.

We must also think about the personality and moods of the individual. We often think of old age as being a miserable time, but most older people say that they are satisfied with life. Older people seem less likely to experience the emotional ups and downs that younger people tend to have. A person's personality does not really change when they 'become old', but they do tend to be more concerned about their inner thoughts and feelings.

Is old age just about these physical and mental changes?

These physical and mental changes are obviously important aspects of growing older. However, there are other factors which are not as obvious. These include:

- significant changes or events in the person's life
- changes in the way a person views their life
- the way society treats older people

What are the major life events that are linked to old age?

Old age is associated with several important life changes, such as bereavement and retirement. The 'empty nest', when the person no longer has to look after children at home, can also be significant. The older person has to cope with these changes and there may be psychological effects and changes in the person's lifestyle.

For some people, it is difficult to adjust to these changes. Many widowed people find it difficult to accept the loss of their husband or wife. However, these changes are not always negative. Some older people find opportunities to do new things or things that they have always wanted to do.

Does the idea of death affect people who are near the end of their lives?

A feeling that death is not so long away is perhaps the unique thing about old age. However, older people appear to be no more afraid of death than anyone else and it is not something that they spend time brooding over.

Nevertheless, it is still an important thing in a person's life. Perhaps it makes them less willing to make long-term plans, or they might decide to do something that they have always planned to do. It may lead people to think about the good and bad things that have happened in their lives. Some experts think that knowing that you are near the end of your life tends to make a person withdraw from society.

In what ways do you think society or other people 'make' a person old?

In many ways, old age is something that society has created. For example, retirement is something that is new. Years ago people would work until they were no longer fit. Often, retirement means that the person becomes a lot poorer that they used to be. Also as a society, we have rules and expectations about what old people should and should not do. We will look at this in more detail later.

What about the very old?

The elderly people who are admitted into a care home are usually very frail and dependent. However, these people are very much the exceptions as most older people are fit and active. In fact:

- only about 3% of people aged 65 or over live in care homes or hospitals
- only 21% of people aged 75 or over require substantial care and support

If we look at those people who are admitted to long stay care, then we can see that many are physically frail and/or mentally impaired. These people may be unable to look after themselves, or are a danger to themselves, but there are many other reasons why people come to live in long stay care. Reasons include:

- loneliness
- lack of community care
- family unable or unwilling to help
- bereavement
- inadequate or inappropriate housing

It is very important that all staff recognise that every resident is different. Each person has unique abilities, needs and requirements and the care that we provide should take this into account. (We will be looking at this in more depth in the Unit on Care Planning).

AGEISM - ATTITUDES TOWARDS OLDER PEOPLE

You will have realised by now that old age is a very complex thing. Getting older will mean different things for different people. However, younger people tend to treat all older people as if they were worn-out and ready for the scrap-heap. Of course this is not true, but when we see the very frail people who live in care homes, it is even more difficult to see beyond their physical or mental problems and to see the real person underneath. This kind of attitude is known as **Ageism**. Ageism is similar to other *"isms"*, such as:

- **Sexism** - discrimination against women
- **Racism** - discrimination against people from different ethnic backgrounds

All these *"isms"* work in the same way:

- We tend to treat people in a particular group as if they were **different and inferior** to the rest of us. (For example sexism, where all women are assumed to be unable to do important, high-pressure jobs and only really interested in bringing up a family. This is obviously not true - there are many examples of successful women in business and politics!)
- We assume that **everybody in that group is the same.**

- We make **people fit in with what we expect.** (For example, women may not be given the same career opportunities as men, so that on the whole they are can't be as successful as men!)

This kind of thing happens to older people also. Just because they have grey hair and wrinkles, or some kind of disability, we see them as useless and worthless. We forget that this person is still an individual and we expect them to act like an "old person".

You may throw your hands up and say "I never treat older people like that". But we often do and say ageist things **without knowing that we are doing them.** Even with the best intentions we tend to patronise older people. When we call someone an "old dear", is it being affectionate, or is it making someone fit in with our idea of what old people should be like?

WHAT'S IN A NAME?

To illustrate this point, think about the different words used to describe older people. In a recent survey (The British Gas Report on Attitudes to Ageing, 1991), most younger people said that they used the words **elderly** and **older people** most often, with very few younger people using the words **senior citizens** or **retired.** In complete contrast, older people themselves did not like the words **elderly** or **older persons**, preferring to be called **senior citizens** or **retired.**

The words we use to describe different groups in society can put people in a good or bad light. The word elderly sounds very dreary and suggests frailty and decline. Older people may prefer the word senior citizen, because it stresses a person's rights and position in society. The word retired covers everybody above retirement age and does not imply that the person is frail or disabled.

AGEISM AND CARE OF THE ELDERLY

We are all guilty of ageism. The big problem is when our attitudes are translated into the way we provide services for older people. As a society we have very low expectations about old age:

- We expect to have less money
- We expect to have nothing to do
- We expect to have poor health
- We expect to look horrible

- We expect to have poor caring services for which we should be humbly grateful

In general, older people are forced to accept things that the rest of us would find totally unacceptable. In some homes, the routine is very strict and residents have to fit in with everybody else. You might have to get up and go to bed at the same time as everyone else, or at the same time every day. You might have to eat your meals with everybody else, even though you want to be alone. The better homes are flexible enough to allow people to have their own daily routine. But even in the best homes, most residents spend most of their time either sitting doing nothing or dozing in a chair. Of course you don't want to be up and doing things all day, but you may get to feel very bored.

You might not like your life in the home, so what are you going to do about it? Would you complain? Perhaps you would, but wouldn't you be afraid of what might happen to you? Do you want to be seen as a trouble-maker? Perhaps you have said something and nothing has happened and you give up.

AGEING AND AGEISM

Activities

Activity 1.1 WHEN IS 'OLD AGE'?

This activity should be done in pairs or in a small group.

Each person should write their answers to the following questions. When everyone has finished, discuss what you have written with each other.

1. Divide a person's lifetime into different periods (eg. childhood, old age, etc.)

2. When does a person become old?

3. Does everybody become old at a certain age?

4. Is a person's age a good indicator of whether they are old or not?

5. Can you divide old age into different periods?

Activity 1.2 WHAT WILL I BE LIKE WHEN I AM OLDER?

This activity should be done in pairs or in a small group.

Spend a few minutes thinking about what you will be like when you are 75 years old. Write down your answers to the following questions and then discuss them with each other.

1. What will be different about you when you are 75?

2. In what ways do you think you will be the same as you are now?

3. What do you think you will enjoy about being 75?

4. What things do you think you will not enjoy?

5. What things do you think you will miss when you are older?

6. What do you think you will feel 'inside' when you are 75?

Activity 1.3 BIRTHDAY CARDS

This activity should be done in a small group.

First of all each person should get hold of a couple of birthday cards that describe a person getting older.

Describe each card according to the following questions (use a separate sheet for each card).

1. Give a visual description of the card.

2. What words are used on the front and inside the card?

3. What is the card's message (eg. losing your memory or getting wrinkles)?

4. Does the card give a positive or negative view of ageing?

After writing down your answers, get together in a group and go through and discuss what you have written. Think about the following questions:

5. What kinds of attitudes are shown by the cards overall?

6. Why do you think people find these cards funny?

7. Do you think these kinds of cards are a good or bad thing?

8. Are there any differences in cards intended for women and cards for men?

Activity 1.4 AGE STEREOTYPES

For this activity you need to be in a small group.

A stereotype is a kind of picture that we have in our minds about different groups of people. Sometimes these are very negative pictures. For example, we often think of old people as cantankerous or miserable. We may also have positive stereotypes. For example we may see old people as wise and contented. The thing about stereotypes is that we try to make people fit into the ideas that we have in our minds, rather than look at them as individuals.

First of all, think of 10 different negative stereotypes about older people, and jot them down. Then think of 10 different positive stereotypes. After you have written them all down, compare your lists with the other people in your group and discuss the following questions:

1. Is it easier to think of negative things or positive things about old age?

2. Think about older people you know. How well do they fit in with your stereotypes?

3. Are your stereotypes just for older people, or can they describe younger people as well?

Activity 1.5 **FEELING YOUR AGE**

This activity can be done on your own, but is best for pairs or small groups.

Answer the following questions and think about your answers. If possible, discuss your answers with other people.

1. How old are you?

2. How old do you feel at the moment?

3. How old do you feel generally?

4. How old would you like to be?

5. How old do you think you would feel at age 75?

Activity 1.6 **LOOKING AT YOURSELF**

This activity can be done individually, in pairs or in small groups.

Take a good long look at yourself and answer the following questions:

1. What signs of increasing age can you see?

2. How has your lifestyle changed over the years?

3. How has your social life changed?

4. In what ways do these changes make you feel good?

5. In what ways do they make you feel bad?

Activity 1.7 AGE AS A BARRIER

This activity is best for discussion in small groups.

Age is important in our society, as a way of deciding who qualifies to do certain things, (for example, you must be 17 or over to drive a car, 18 or over to vote, etc.).

Are there any things that people **can't** do simply because of old age? (for example, to serve on a Jury in the Crown Court). Are there any other things for which age is a barrier?

Are there any things to which **only** older people are entitled?

Project Suggestions

Each person should do only one project for each unit, either individually or as part of a small group. The topics you choose for project work will arise directly out of discussion during the Training Session and Activities.

This list is just a few suggestions to get you started. The project you choose should have practical relevance to your own work within the Home.

Project 1.1 **WHAT'S IN A NAME?**

Following on from the discussion during the Training Session, ask residents in your home which words they prefer, which they don't like, and why they prefer or dislike certain words:

elderly
older people
old age pensioners
senior citizens
retired
some other word (make a note of these new suggestions)

How does this match up with the discussion you had during the Training Session?

How does this match up with the results of the British Gas Report on Attitudes to Ageing? (look in your Course Notes to remind yourself of this)

Look at the brochure and other printed material about your Home, and think about conversations you have with relatives and with professional visitors. What words are used to describe residents? Do they fall into the group of *preferred* words? Can you do anything to improve on this?

Project 1.2 **REASONS FOR LONG-STAY CARE**

During the Training Session, you discussed possible reasons for coming to live in long-stay care. This project is designed to follow on from this discussion.

Talk to your residents, and find out why they came to live in the home. What prompted their decision? What were they hoping to find here?

Project 1.3 DOING UNTO OTHERS...

This project is designed to follow on from the discussion during the Training Session. During this session, you were asked to consider what you would feel like if you yourself lived in the home where you work, and what you would like and dislike about living there.

Talk to your residents, and try to find out what they like about living in long stay care, and what they dislike about it.

How do these things match up with your discussion in the Training Session? Do residents like and dislike the same things that you yourself thought you would like/dislike about living in long stay care?

Are these things specifically about this home, or would they be the same in any other establishment as well?

AGEING AND AGEISM

Background Material

This is a list of background material for Unit 1. It has been divided into 2 sections. The first section is recommended for everyone to do. Section 2 is more advanced information, for people who already have more experience in this area, or who would like to go into it in more detail.

Section 1 **Recommended for all students:**

Video: *"Celebrating Age" - Jane Saxby* (Institute of Human Ageing)

Book: Chapter "What is Ageing?" pages 99-111, *"Taking Good Care"* (Jenyth Worsley, Age Concern England)

Article: *"Ageism - Its Effect on Services"* (Joy Bounds, Institute of Human Ageing)

Factsheet: *"The Ageing Population"* (Dr Andrew Sixsmith, Institute of Human Ageing)

Section 2 **Advanced Level:**

Bond, J., Coleman, P. & Peace, S. (eds) **Ageing in Society: An Introduction to Social Gerontology**. London: SAGE Publications (1993).

Bill Bytheway **Ageism**. Milton Keynes: Open University Press (1995).

Paul Johnson **Income: Pensions, Earnings and Savings in the Third Age.** Research Paper No. 2, Carnegie Inquiry into the Third Age (1992).

Eric Midwinter **The British Gas Report on Attitudes to Ageing 1991.**

Ken Tout **Ageing in Developing Countries.** Oxford: Oxford University Press (1989).

Christina Victor **Health and Health Care in Later Life.** Milton Keynes: Open University Press (1991).

Warnes, A.M. (ed.) **Human Ageing and Later Life.** London: Edward Arnold (1989).

Tony Warnes **Homes and Travel: Local Life in the Third Age.** Research Paper No. 5, Carnegie Inquiry into the Third Age (1992).

QUALITY OF CARE AND QUALITY OF LIFE

OBJECTIVES OF UNIT

This unit has the following aims:

- To look at what makes a good quality of life in a care home;
- To look at some of the reasons for bad practice in care homes;
- To look at how good care can promote a resident's quality of life.

GIVING GOOD CARE

If you speak to anyone working in a residential home, nursing home or hospital for elderly people, they will usually say that they provide good care. But exactly what do we mean by *"good care"*? In the old days, many old people lived in workhouses, hospitals and mental asylums. These places were often seen as models of good practice, with the matron or hospital governors proud of the efficiency of their institution. Over the years, people came to realise that life in a workhouse or asylum was not so pleasant after all.

We can say that things are different now, that we have come a long way since the bad old days. Of course things have improved, but should we feel satisfied about the care that older people get?

A survey in 1991 of over a hundred homes in Greater London, by the charity Counsel and Care, painted a very bleak picture. They found that many elderly residents were routinely humiliated through inadequate facilities and lack of respect by staff for residents' rights, dignity and privacy. The report concluded that faced with having to share rooms and use commodes, unlocked toilets and bathrooms, then wetting the bed can become an "attractive solution" for residents!

REASONS FOR BAD PRACTICE

Despite things getting better, there is still a lot of bad practice around. So let us try to think why this happens. Some people might suggest that it is because the staff are themselves 'bad' people. There may be a few such people, but these are very much the exceptions. The vast majority of staff in homes are honest, decent people, most of whom want to do a good job.

Some people might argue that bad practice occurs because there is too little money and too few staff to cope?

There may be some truth in this, but it is also an easy excuse for sloppy work and laziness. So what are the real reasons? Here are few suggestions:

- **Having a routine or stuck in a rut?** Firstly, whatever job they do, people tend to have a routine, or a particular way of doing things. When this happens it is very difficult to see beyond it. Things seem to be working smoothly and it's the way things have been done for years - so it must be OK! Having a routine is important. It helps people to work efficiently. The problem comes when the routine becomes more important than the people in the home. Many residents are afraid to ask for things or to complain. They soon learn to fit in with life in the home. The person who doesn't fit in is then seen as the 'problem' or the 'awkward' resident.

- **Bad habits**: While most of us want to do a good job, we often develop bad habits. If these are allowed to continue, then they soon become part of everyday life in the home.

- **Low expectations of old people**: Because a person is old and infirm, we may think that they are unable to do things or have no interests. If we underestimate residents, then they will tend to fit in with our low expectations. Everybody needs encouragement and help, whether they are old or young. But this may be especially true of residents who may lack confidence in themselves.

SOME PRINCIPLES OF GOOD CARE

So we need to make sure that we do not fall into any of these traps. When you provide care for an elderly resident it is a good idea to remember three important principles.

- Firstly, **do unto others as you wish them to do unto you.** If you were the resident, or a member of their family, would you be happy with the care that was being provided?

- Secondly, a Care Home is the **home of the residents who live there.** Is the place like a real home, or does it feel more like an institution? There may be things about the physical environment or the care that is provided that may make it feel *unhomely*.

- Thirdly, whenever you do something, however small, always ask **in whose interests** are you doing it. Are you really doing it in the interests of the resident, or are you doing it because it makes your life easier or because you have always done it?

WHAT DO WE MEAN BY "*QUALITY OF LIFE*"?

When we talk about good care we should be talking about improving the **quality of life** of residents. It is important to look at this from the point of view of the residents themselves. The book **"Homes are for Living In"** states that the quality of life of residents depends on six key things:

- **Privacy** is the freedom from the intrusion of others and the right to be left alone and undisturbed. In a residential or nursing home, it is often difficult to find privacy. Carers should be sensitive to the needs of each individual, and the problems they might have in getting the privacy they need.

- **Dignity** is not about being snobbish or grand. It is about treating a resident with respect and decency at all times. Older people are not children and shouldn't be treated as if they were children. Residents should not be subjected to things they find degrading and particular care should be taken with intimate, personal care such as bathing, dressing and toileting.

- **Independence** is having the freedom and opportunity to act without reference to other people, including the right to incur some level of risk. People should be encouraged to do things for themselves. More importantly, they should feel in control of their lives. People should not always have to feel obliged to carers for the care they receive.

- **Choice** means that residents should be able to make their own decisions about what happens to them in their daily lives. This may be about what they eat, when they get up in the morning, what they wear, what they do and so on. As far as possible, residents should be able to live their own lives in their own way, rather than have decisions made for them. It is also important that there is a range of options available to choose from.

- **Rights** are the things that every citizen in the country is entitled to - liberty, respect for the individual, proper health care and so on. It is very important to remember that residents **have the same rights as anybody else** and that these should be protected. We shouldn't think that residents are nuisances because they demand things that you or I take for granted. You should also remember that some residents prefer to put up with things rather than speak up or complain.

- **Fulfilment** means to be able to do the things that we think are important in life. Everybody has ambitions and everybody has special things that they like to do. Residents should be able to enjoy life and staff should encourage and help them to do things that make them feel fulfilled.

The key thing to remember is that good care is much more than just keeping residents comfortable and secure. Good care is about providing the right environment in which a

person can find happiness and feel valued as a human being.

It is also important to see people as individuals. Everybody is different. They have different needs, different outlooks on life, different personalities. A resident's quality of life will depend on how staff respond to their individual requirements.

ROLES AND RESPONSIBILITIES

You should remember that everything that you do can have an effect on the residents in the home. Even little things that might seem unimportant might be important to a resident. **Everybody working in a Care Home can make a difference to the quality of life of the people living there.**

Each one of us is responsible for making sure that the best care is given in the best possible way.

PROMOTING RESIDENTS' QUALITY OF LIFE - EVERYONE'S RESPONSIBILITY

The staff of every Care Home are its greatest asset. Without their skills and commitment the home cannot function. Each member of staff should be recognised for their contribution and everyone should understand their tasks and how they affect residents.

Looking at the different aspects of work in a care home, it tends to fall into different types:

- **Home tasks**: These are the things you do to keep the home running smoothly, such as cleaning, food preparation, administration, management and so on.
- **Routine care**: These are the everyday things you help residents with, such as dressing, walking, bathing and going to the toilet. This type of care is about keeping a person healthy and comfortable.
- **Demanding care**: These are the things you have to do because something has happened, such as if a resident has fallen down, or someone is ill.
- **Positive care**: These are the things you do to help a resident to feel better, or happier, or to be more independent.

Clearly, all the different tasks are very important to the well-being of the residents in a home. The **home tasks** and **routine** things are obviously important. The home has to be run well and efficiently. The health and safety regulations and fire regulations have to be followed. Personal care like dressing and toileting all have to be done skilfully. We also have to deal

with the **demanding** situations as they arise. The quality of life of residents also depends on the social contact they get, activities and so on.

However, there is a tendency to put emphasis on **routine** care in residential and nursing homes. Routine care is often easier to do than **positive care**. It is often easier to do something for a person, than to help and encourage them to help themselves.

Even in very good homes, many residents spend most of their time sleeping or just sitting. Of course these are not bad things in themselves and we shouldn't expect people to be busy doing activities all day. But do think seriously - are you providing the best possible care? Do the residents in your home really feel fulfilled with their lives? However good the home, there is always room for making things better!

Activities

Activity 2.1 FEELING VULNERABLE

This activity should be done in a small group.

Spend a few minutes thinking about a time when you felt some of these things:

- vulnerable
- powerless
- confused
- forgetful

Write down your answers to the following questions and then discuss them with each other.

1. Briefly describe what happened.
2. What did you do?
3. What would have made you feel better?
4. Who did you look to for help?
5. Was this person helpful?

Activity 2.2 BEING THE ODD ONE OUT

This activity should be done in pairs or a small group.

Try to imagine being in a group of a dozen people, where everybody else is either a lot younger, or a lot older, than you. Write down answers to the following questions and then discuss them with each other.

1. How do you think you would feel in that situation?
2. How would you try to fit in with the other people?
3. What problems might there be?
4. How could you get over these problems?

Activity 2.3 BEING IN A STRANGE PLACE

This activity should be done in a small group.

Think about when you last started a new job or went to a home or hospital you did not know. Write down your answers to these questions and then discuss your answers in a group:

1. What was strange about the new place?
2. How did you cope with these problems?
3. What made things easier for you?
4. What made things more difficult?
5. Are your experiences similar to older people who are admitted to a care home?
6. How could we make things easier for new residents?

Activity 2.4 THE MEANING OF *'HOME'*

This activity should be done in pairs or a small group.

Every residential or nursing home tries to be homely, but what do we mean by *"home"*? Start by thinking about the place where you live, and answer the following questions:

1. What does home mean to you?
2. What turns your house into a home?
3. What is it about some people's houses that makes them *'unhomely'*?
4. Do you have more than one home?
5. What are good things about being at home?
6. What are the bad things?

Now compare your answers with those of other people in your group. Does everybody feel the same way? Make a list of everybody's ideas about *"home"*.

Now think about the residential or nursing home in which you work. Does the place feel homely according to all these different meanings of home?

Project Suggestions

Each person should do only one project for each unit, either individually or as part of a small group. You should choose a project based on one of the six ideas about quality of life, mentioned in the Course Notes. As in Unit 1, the list of projects given here is just a suggestion to get you started.

You will find the book "Homes are for Living In" is helpful in developing your project.

Project 2.1 **PRIVACY**

Discuss exactly what is meant by *"privacy"*, so that everyone knows what it involves.

Find out about the privacy needs of the individual residents in your home.

Look at the care practice in your home to see whether you are meeting the privacy needs of your residents.

Outline a code of practice for ensuring privacy in your home.

Project 2.2 **DIGNITY**

Dignity is about treating residents as individuals and treating them with respect. Review care practice in your home and answer the following questions:

Are residents really treated as individuals or as "patients" or "clients"?

Is the care in the home based on the individual needs and living patterns of the residents, or on efficiency or staff convenience?

Ask individual residents if they really feel "at home". For example, do they feel part of a family group? Are they comfortable? Can and do they personalise their bedrooms? Do they feel that they can do what they want, when they like?

Project 2.3 **INDEPENDENCE**

Look at care practice in your home in respect to:

- encouraging and assisting people to do things for themselves

- allowing and encouraging people to take control of their lives

Are you meeting these needs for your residents?

Project 2.4 **CHOICE**

Choice is about being able to make decision about your life, based on a range of options. Review care practice in your home and consider the following questions:

Are there spoken or unspoken 'rules' about what residents should do? For example, which lounges they should sit in, when they get up or go to bed or have a bath and so on?

What range of choices do residents have about their daily life? For example, what they eat, and where and when they eat?

What choices do residents have regarding their living space? Can they use bedrooms whenever they want? Can they go outside when they want? Can they choose their own furniture?

For many residents, making choices is very difficult. What can be done to help and/or encourage them?

What happens if a resident refuses to fit in?

Project 2.5 **RIGHTS**

It is important to remember that the residents in your home have the same rights as the rest of us. Think about what these rights are.

Discuss and list all the possible situations that might arise in a home where a resident's rights may not be upheld. For example, is there any evidence that a person's liberty is being restricted, however insignificant that might appear? Are residents expected to do things that they don't really want to do?

What do you as staff think about the rights of residents?

How can residents' rights be protected?

Are there any aspects of the daily routine or the physical environment of the home which compromise residents' rights?

Project 2.6 **FULFILMENT**

Fulfilment is about encouraging and helping residents to make the most of their lives.

For each resident:

- find out what they like to do or what gives them pleasure?
- when they like to do it?
- who they like to be with?
- whether there are things they would like to do, which they don't do at the moment?

Look at current care practice in your home.

Are residents being encouraged/helped/stimulated in these things?

QUALITY OF CARE AND QUALITY OF LIFE

Background Material

This is a list of background material for Unit 2. It has been divided into 2 sections. The first section is recommended for everyone to do. Section 2 is more advanced information, for people who already have more experience in this area, or who would like to go into it in more detail.

Section 1 **Recommended for all students:**

Book: Introduction and Chapter "What Makes a Good Carer?" pages 16-34, *"Taking Good Care"* (Jenyth Worsley, Age Concern England)

Book: Chapter "Principles of Good Care" pages 48-55, *"Taking Good Care"* (Jenyth Worsley, Age Concern England)

Paper: *"Quality of Life"* (Dr Andrew Sixsmith, Institute of Human Ageing)

Book: *"Homes Are For Living In"* (HMSO)

Booklet: *"Quality of Life"* (Court Cavendish)

Section 2 **Advanced Level:**

Counsel and Care — **Not Such Private Places**. London: Counsel and Care (1991).

Counsel and Care — **From Home to a Home**. London: Counsel and Care (1992).

Tracy Kidder — *"The Last Place on Earth"*, in **The Last Place on Earth**, Granta Volume 44. London: Granta Books (1993).

D.M. Willcocks, S.M.Peace & L.A. Kellaher — **Private Lives in Public Places**. London: Tavistock Publications (1987).

P.J. Youll & C. McCourt-Perring — **Raising Voices: Ensuring Quality in Residential Care (An Evaluation of the Caring in Homes Initiative)**. London: HMSO (1993).

PLANNING CARE & ADMISSION TO A HOME

OBJECTIVES OF UNIT

In Units 1 and 2 of this course we looked at some ideas about the quality of service we provide in care homes and the quality of life of the residents who live in them. Now we need to start putting these ideas into practice. In this unit and the next, we will be looking at **care planning** as the way we can ensure that we give the best care we can to the residents.

We will begin by looking at the admission of residents into the home and then we will consider the ongoing care planning once a resident becomes established. It is important to stress that this Unit is not a user guide or care planning manual. Rather, the aim is to help people to get a better understanding of the care planning process in general. After completing this Unit, students should:

- understand why care planning is necessary;
- know the main principles of care planning;
- be aware of the problems associated with admission into a care home;
- appreciate how care planning can enhance the quality of life of the people who live in the care home;
- understand their own role in the care planning process.

GOING INTO A CARE HOME

To begin with, we will examine the care planning of people who are being admitted into a care home. This is a very important time for an elderly person. The upheaval of leaving home can be very stressful. For some people, leaving home will be almost like a bereavement. For others, it will be something they welcome.

From a caring point of view, the admission period is also an important time. It is the time that resident and carers get to know each other. Mistakes and problems during this period may take a long time to get over.

Living in your own home has many benefits. You feel at home in familiar surroundings, with all your memories and possessions. You feel that you are the master in your own home. On the other hand people who are becoming increasingly frail, may find it too difficult to cope with living in the community. For these people, going into a care home may be a welcome relief. People who are very lonely or anxious about being on their own may also prefer life in a care home.

However, there are disadvantages to living in a care home. Some people might see it as the "end of the line". Some may feel that they will lose their independence, because they will have to consider the wishes of other people all the time.

ROLE OF THE CARE TEAM DURING THE ADMISSION PERIOD

There are two key lessons to be learned. Firstly, the decision to go into a home is never straightforward. On the one hand, there may be very good reasons for admission, but this rarely happens without regrets on the part of the new resident. When the decision is being made, the emotional factors are often seen as less important than *"risk"* factors, such as safety and the ability to carry out activities of daily living.

A second point is that everyone is an individual; different people will react in different ways to being admitted into a care home. Some people will approach it in a more positive way, while others will find it difficult to leave their familiar surroundings. For others, it will be a traumatic time and some people may be very confused about what is happening to them.

These points provide the **two key aims** of care during the admission period:

- **helping the person to adapt** - because of the disruption to the elderly person's life, we have to make the transition from their own home into a residential home as painless and smooth as possible;

- **finding out about the person** - because everyone is different, we have to assess their needs, wishes and abilities and match these with appropriate care.

To do these properly, we need to go about them in an organised way. This is where care planning is essential.

WHAT EXACTLY IS A "CARE PLAN"?

Some of you will be very familiar with care planning, not only in the home you now work in, but in other establishments in which you may have worked in the past. But even so, do you really know what a care plan is? The following points are important:

i WHAT IS A CARE PLAN?

- A care plan is **about the service that you provide**;

- It is a **written document** that the care team can use when working with a resident;

- It is a clear statement of the person's **wants, preferences, needs and abilities**;

- It is an **agreement between the Care Team, resident and relatives** about the care that is being provided.

ii WHAT DOES CARE PLANNING AIM TO DO?

- A care plan is a tool to help staff to plan and organise their work to **meet a person's needs** more fully;
- It is an **Action Plan**, including clearly defined goals and the means for achieving these goals;
- It is a way of **measuring progress** towards the stated goals;
- It is a way of ensuring **good communication** between members of the care team;
- It is a way of ensuring **continuity of care.**

iii WHAT IS IT NOT?

- It is **not** just about solving problems or meeting a person's basic physical needs - it is about **maintaining or improving their quality of life;**
- It is **not a static** document - goals are reached and a person's needs and abilities change and the care plan must change also;
- It is **not just paperwork** - the important thing is the care you provide; the paperwork simply captures the care plan.

MAKING A DIFFERENCE

One more point is that **everyone** in the home makes a difference to the life of the resident. You can never avoid adding to or taking away from their quality of life. It follows that everyone has to play a part in the care planning process, whether you are a cook, handyman, secretary, manager or part of the direct care team.

CARE PLANNING - THE FIRST FEW WEEKS

The procedure for admitting residents into a care home is based on a number of steps. We will not be able to cover them all in detail here. Also, the actual forms and documents used will vary from home to home, so it is important that you familiarise yourself with the ones

that are actually used in your home, as part of your background work. The main steps usually include:

- Assessment Prior to Admission
- Admission Care Plan

i. Assessment Prior to Admission

This is the first point of contact between the resident and the home. This can sometimes occur wherever the person is coming from, such as a hospital or their own home. Ideally, it should take place in the care home, but **before** actual admission.

The assessment prior to admission should be a general, rather than detailed, view of the person. There should be a few key questions to draw out information about the person's previous experiences with care and about their basic needs and expectations. The are two aims:

- It provides an opportunity for the elderly person to hear about the care home, so that they are properly informed before they are admitted;
- It allows us to check whether the person is "right" for the home. The key question here is whether the home can cope with this individual **without diminishing the care provided to others in the home.**

ii. Admission Care Plan

This is the main care planning document during the admission period. In some systems, the documentation used for the care plan during admission is different from the care planning documentation used later on, in other places it is the same. Nevertheless, the Admission Care Plan has **the same five key aims:**

1. To make the resident feel welcome and comfortable;
2. To address any health or social emergencies;
3. To begin the assessment process and share information with the resident and their family;
4. To commence discussion and planning for future care needs;
5. To help the resident with the settling-in process and establish a sense of belonging.

The Admission Care Plan should be seen a process of "getting to know you" for both the resident and the care team. It is important to bear two key things in mind at this stage:

- **Things are going to change**. You have to be non-judgemental about the new resident. Your initial impressions and ideas about the resident may have to be altered. You must assume that you will make mistakes at this stage and you should not feel guilty about it.

- **You need a "healthy scepticism"**. The things you hear from the resident, their family and friends should be taken seriously. This kind of background information is essential to good care. But it is also important not to take everything at face value. For example, you need to ask whether the opinions of relatives under stress are a true picture of the elderly person.

WHY DO WE NEED CARE PLANS?

We have already asked the question *"what is a care plan?"*. Now that we have started to understand the process better, it is useful to ask why we need them? Some people might feel that care plans are unnecessary. Obviously, if we are going to spend a lot of time and effort in care planning we need to know that it is all worthwhile. But do they really fulfil a useful purpose in the provision of care to residents?

THE PROBLEMS OF WORKING WITHOUT CARE PLANS

Some people working in care homes may feel that the paperwork is too time-consuming and that this time could be better spent in actually caring for the residents. But if we work without care plans then a number of problems tend to occur:

- Individual needs and preferences are not clearly identified
- There are no clear aims in the care provided
- There is no way of measuring progress
- There is no written communication - you have to depend on word of mouth and on your memory
- It is difficult to ensure continuity of care to the resident

Without care planning, these problems would make it very difficult to give individualised care to meet the person's particular needs.

BENEFITS OF WORKING WITH CARE PLANS

Many of the problems just mentioned can be solved through care planning. The big thing to remember is that good care is **not about problem-solving** but **about maintaining or improving the quality of life** of residents. If we are really serious about this, then care planning is essential:

- While care planning may seem a lot of effort, by looking ahead, we can deal with areas of concern or crises before they even occur. This extra effort at first soon makes life easier and less stressful for care staff and more pleasant for the residents.

- Instead of just reacting to the "here and now", we can work with some specific aims in mind. Care planning allows us to be more organised in our work. This will mean that everybody's needs will be met and it will allow you to use your time in a much more **"positive"** way (see Unit 2).

DISADVANTAGES OF CARE PLANNING

While there are many benefits associated with care plans, there are some dangers.

- It is important that care planning does not become an end in itself - a care plan is simply there to help and encourage staff to provide the best possible care for an individual.

- The care we provide should not be rigid and it has to be flexible enough to respond to the ever-changing needs of the resident. This means that care plans have to be constantly reviewed.

- The information held in a care plan may be sensitive or private and confidentiality should be respected at all times. There is no necessary right to have detailed information unless the resident or relatives agree to it.

THE CARE PLANNING PHILOSOPHY

Before we look at care planning procedures in detail, it is useful to spell out the principles of good care planning:

- Care planning is about **holistic care**. Health and disability problems are important, but long-term care should be concerned with the **quality of life** of the person.

- Care planning is about **empowerment.** We shouldn't see care just as a set of tasks which are "done to" a resident. Instead of the usual practice of building care around

their disability, we must ask **how can we help a person** to continue their lifestyle, taking into account any abilities and disabilities?

- Care planning is about the **individual**. This means paying attention to their specific needs and preferences. So care planning must begin by asking them what their views are.

- Most elderly people's **needs and wants are not unachievable**. Most will have already come to terms with any disability and their situation in life. So we should usually be able to meet their needs.

- Care planning is also about **negotiation**. While we have to look at how the **resident** sees their needs and wants, it is still important to look at how **relatives** and **staff** see them. The care plan should be a three-way agreement based on the views of all three parties.

ON-GOING CARE PLANNING

Now that we have seen why care planning is so important, we need to look in more detail at the care planning for residents after the initial admission period has passed. As before, the actual documents will vary from home to home, so you should familiarise yourself completely with the ones you use already.

The main documents are usually:

- Essential Information
- Care Plan
- Daily Resident Diary

i. Essential Information

This speaks for itself. It is the vital information on the main care factors for an individual resident. These include personal details about the resident, family contacts and medical/nursing contacts and information such as special medication that they might require, medical conditions and special risk factors, such as suicidal tendencies or being prone to falls and so on.

There are two things to remember about the Essential Information Sheets:

- They need to be **immediately accessible** for care staff to consult.

- Because people change, the Essential Information Sheets need to be **regularly reviewed and updated.**

ii. Care Plan

After the initial settling-in period and after the admission care plan review has been undertaken, the resident's long-term care needs are set out in the care activity plan. This is written over a two-week period by a senior member of staff who should have built up a rapport and relationship with the resident in the previous weeks. The care plan has five main stages:

1. Firstly, the person who is writing the plan needs to assess **what the main areas of concern** for the resident. In particular, we need to know the things that spoil or interrupt their lifestyle and quality of life. To do this we need to get an idea of what their life was like before they came into the home or the time before their disability. Hopefully, some degree of their previous lifestyle can be brought into how we care for them in the home.

   The care plan is not just about physical health or disability, it is about quality of life, so it is important to remember what was discussed in Unit 2. What one person sees as a good quality of life may be very different to another. So it is important to find out what the residents themselves feel is important in their lives.

2. The next step is to find out what the **resident's expectations** are about themselves and what they want the care provided in the home to achieve. For example, if they have had a stroke, do they expect to walk again? Do they expect rehabilitation care to help them achieve this?

   The member of staff who is doing the assessment has to be very careful and skilful here. We have to look below the surface of what the resident actually says and try to understand what their real motives are. If the stroke victim says they want to walk again, is this because they really expect to walk again or because they don't want to have to rely on care staff to help them? This understanding will be crucial when it comes to specifying the care for the resident.

3. The third stage is what the home care team **believe can be achieved**. It is here that we look at the practical limits of the resident's abilities and disabilities and the resources in the home. Planning care can involve making some compromises and it may be that a resident is asking for something that is impossible and the reality of the situation will have to be explained to them. But this does not happen very often and a resident's choices and preferences can usually be met.

4. The next stage is the actual **specification of the care activities** in a plan of action. It will be a set of clear, simple instructions or statements about the resident's care,

written in plain English. There will be a separate sheet for each of the key aspects of the care, such as mobility or incontinence.

5. Finally, the activity care plan looks at the different **responsibilities for care**. It is important to remember that care is also the responsibility of the resident and family and friends. The activity plan should say exactly what parts the **resident**, the **home care team** and the resident's **family and/or friends** play in carrying out the care activities.

The care plan should not just be about a resident's dependency and how to cope with it. Instead it gives an **overall picture of their need for different aspects of care,** including **'positive'** care interventions as well as everyday routine care. It should give a good guide to the amount of staff time that is needed for a resident and the inputs from different staff. The care plan should point out the resident's strengths, weaknesses and disabilities and indicate the sort of care they require to meet these needs.

After admission, the care provided to a resident should be reviewed on a regular basis, usually about every month. The aims of the care plan review are to:

- make sure that the **care objectives have been achieved;**
- to see whether the **care objectives are still relevant;**
- to make sure that the resident has been **helped though the critical stage** of admission into the home;
- get the views of **staff, clients and relatives** about the care that is being provided.

This last point is important. The care plan review is not just about reviewing the resident. It is also about reviewing ourselves as care providers and looking at the role of relatives. We often fall into the trap of seeing the resident as having "failed" when the care plan objectives have not been met. The real reason for this *"failure"* is often that we are not providing the right kind of care.

iii. Resident Diary

The resident diary is used to record the ongoing welfare of the resident and staff activity in respect to the care plan. It is a legal requirement of the home's registration to keep a daily diary on residents, with a minimum of one entry every 24 hours. Ideally, there should be **two** entries made each day, for the day and night shifts.

Diaries are not always kept properly. There should never be a time when you write down "nothing to report". The daily diary should be tied in with the aims and activities laid down in the care plan.

The diary should also mention any other aspect of the resident's welfare that is relevant to their care, such as visits from doctors or contact with relatives. The diaries are there to help staff and should be used to:

i. show how a resident is being cared for;

ii. provide daily information to help with further assessment of the resident's needs;

iii. check that care activities in the care plan have been done.

A diary should be filled in with a lot of care. The following things need to be borne in mind:

- It should be accurate and based on real facts and evidence rather than just opinions
- It should be a balance of positive and negative things, so it is about achievements as well as problems

The evaluation of care - whether the care plan is working or not - is based mainly on these daily reports. The diary should pick up where things are going right or wrong. If the care plan is not working, then it will be necessary to:

- review the care plan to see whether it is still appropriate
- look at the motivation of the resident
- see whether any practical difficulties are getting in the way of the care plan
- see whether staff are carrying our the care plan properly

All staff should be encouraged to fill in the diary, but sometimes only a senior member of staff should make the entry. Even then, information from **all** staff will be important.

OTHER CARE PLANNING DOCUMENTS

We have covered the major approaches to care planning, but it is useful to briefly touch on some of the other possible aspects:

- ### Essential Care Plan

  Some care planning systems have a separate "essential care plan", which outlines the special care that a resident must have to avoid a serious breakdown in their health or welfare. It can be used for people who require special care on a permanent basis or for people who are going through an acute phase of illness or a temporary emotional or behavioural problem.

Personal Profile

The personal profile is a **written picture of the resident**. If able, the resident can write it themselves. Otherwise, the careworker writes it with the help and permission of the resident or their family and friends. There are no set rules for the personal profile and it could range from a few lines to several pages. The aim is to get a better idea of who the resident is, their life history, previous lifestyle, likes and dislikes, etc., so that this can be built into their care.

Resident's Choices

Good care is about helping people to feel fulfilled by giving them what they really want, so we need to have information about their personal preferences and choices and ways of living. This should cover preferences in respect to things like foods that are liked and disliked and the resident's leisure and recreational interests.

Activities

The first 6 activities focus on admission to a care home, while the next 6 look at issues around planning care. Make sure that you do activities covering both of these areas.

Activity 3.1 **BEING IN A NEW PLACE**

This activity should be done in a small group.

Spend a few minutes thinking about a time in when you were in an entirely new place, where you didn't know anyone and where everything was unfamiliar, say the day you started a new job or your first day at a new school. Write down your answers to the following questions and then discuss them with each other:

1. Briefly describe the situation.

2. How did you feel?

3. What would have made you feel better?

4. How did you cope with settling in to the new place?

Activity 3.2 **A LIFE IN A SINGLE ROOM**

This activity should be done in a small group.

We all know how important our possessions are to us. One of the main problems of moving into a care home is that the person has to leave behind their home and most of their possessions. Imagine there was a fire in your house and you only had time to save a few things - just enough to fill a single room or bed-sit [but assume people and pets are safe!].

Firstly, spend a few minutes thinking about the sorts of things that you possess, such as clothes, furniture, mementoes, household appliances, etc. Answer the following questions and then discuss them with each other.

1. What things would you save?

2. Why are these so important to you?

3. What would you feel about losing all your other possessions?

Activity 3.3 LEAVING YOUR HOME

This activity should be done in pairs or in small groups.

In the last Unit, one of the activities was concerned with the **meaning of home.** A person's home is usually the most important place in their life. It is a place where you feel you belong, It is the place where you live with your family. It is the place where you feel comfortable and able to be yourself. Answer the following questions and then discuss them with each other.

1. Why is your home important to you?

2. Think of reasons why you might leave your present home.

3. How would you feel if you had to leave your present home?

4. Do you think an elderly person would feel the same or differently to you, if they had to leave their home?

Activity 3.4 QUESTIONING THE WAY THINGS ARE

How can a resident complain or raise an issue in the first few weeks, without feeling that they are a nuisance? Think about the following situations and try and answer the following questions. If possible, discuss them in pairs or a small group.

1. If you were a guest in somebody's house but their cooking was horrible or they tried to feed you something you can't eat (for religious or health reasons or something you just hate). How would you approach the matter without causing offence or embarrassment?

2. How could you complain about somebody's driving if they offer or are giving you a lift somewhere?

3. How would you raise an issue in a new job if every day you ended up working 20 minutes longer than your shift? Or if you suddenly discovered that the laundry was too busy so you would be expected to launder your own uniform?

4. Think about the worry these situations give you, and then ask yourselves how easy is it for a new resident to complain or raise an issue in the first few weeks without feeling like a nuisance or falling out with staff?

Activity 3.5 THE PROSPECT OF CARE

This activity should be done in a small group.

When an elderly person becomes too frail to look after themselves, then they may have to think about moving to a place that can provide a more supportive environment. Admission into a care home is only one of a range of alternatives. Try to think from the point of view of residents in your care home about the benefits and disadvantages of the following options:

- Living in their own home
- Living in sheltered accommodation
- Living in the home of a son/daughter
- Residential or nursing home
- A long-stay hospital

To help you compare your views, draw a large box on a sheet of paper and divide this into smaller boxes like the following diagram. List the various living arrangements along the top, and down the side write "pro's" and "con's":

	Own Home	Care Home	Sheltered Accommodation	Living with son/daughter	Long-stay Hospital
Pro's					
Con's					

Activity 3.6 NEW INTO A HOME

This activity should be done in pairs or a small group.

Imagine that you are a new resident in your care home. Answer the following questions and discuss your answers with each other.

1. What would you want to know about the home?

2. How would you find these things out?

3. Does your care home do enough to give a new resident the information they need?

Activity 3.7 WORKING WITH THE FACTS

This activity should be done in a small group.

Knowing about the life of a resident can be very important when it comes to caring for them. Below are some examples of "facts" about residents. For each example, ask the following two questions:

- Is the information **useful** or **unneccessary** when it comes to caring for the person? Why?
- Do you think that you should **share** this information with the rest of the people in the care team?

Mrs A, who has dementia, does not like to be bathed. You discover that she was sexually abused when she was a child.

Miss B has never had a visitor in the three years she has been in the home. She tells you that she used to go to church every Sunday.

Mrs C, who has been a widow for twenty years, says that she never liked her husband and that she was glad when he died.

Mr D is disabled after having a stroke. He tells you that he is homosexual.

Mrs E tells you that she worked in a pub when she was younger. You also discover that she had managed a number of smart hotels in the local area.

Mrs F only has one relative, a sister who never visits. Mrs F tells you that the two of them fell out, because her sister borrowed some money from her and never paid her back.

Activity 3.8 THE CARE PLANNING QUIZ

This activity should be done in a large group if possible.

One person should act as quizmaster. The quizmaster should read out the questions from the care Planning Quiz on page 49, without referring to the answers.

When everyone has jotted down their answers, the quizmaster should ask people in the group what they thought was the right answer to each question in turn and what their reasons are. After discussing each question, the quizmaster should turn over the page and read out the ideal answer.

Activity 3.9 **SLEPT WELL**

This activity is particularly for night staff.

Records are only useful if we can tell other people what we mean. The phrase "slept well" is used very often in records. But what does the phrase "slept well" actually mean? Ask different staff to describe it in their own words. Now think what "slept well" means when used about different residents in the home.

- Does it mean the same to everyone?
- Could these different definitions of "slept well" give us more useful information in care planning? Try them out by talking to different staff again. Can you find phrases that mean the same to everyone?

Activity 3.10 **DESCRIBING YOURSELF**

This activity should be done in a group.

Each person in the group should write two short descriptions of themselves (just a few lines). The second description should not contain anything that was mentioned in the first one. After you have finished, mix all the descriptions together. Then read them out and see if the group can match them up. The group should then discuss these two questions:

- Are the descriptions easy to match up?
- Do they paint different pictures of the same person?

Activity 3.11 **WHO AM I?**

This activity can be done individually.

Write down "I am..." 20 times on separate lines of a sheet of paper. Then make each "I am" into a description of yourself. This could be something factual, such as "I am a woman" or something about yourself, such as " I am a happy person". But the main thing is to put down things which describe the "real" you. After you have finished, think about the following questions:

- Did you find it easy to make your list?

- What sort of person does it show overall?
- Does it say everything about you, or are there other things you could put down?
- Is there anything about yourself that you would not like other people to know? (You may have left it off your list!)

Activity 3.12 MAKING COMPROMISES

This activity should be done in a group.

Each member of the group should make a list of the following:

- the things that you most like to eat
- the things that you don't like to eat
- the leisure activities you like to do
- the leisure activities that you really dislike

Now imagine that everyone in the group lived together and you all had to eat the same food and do the same leisure activities. Compare each other's lists and make a single list of leisure activities and things to eat that you all agree on.

- How easy was it to agree?
- Was everyone happy with the final list?

CARE PLANNING QUIZ

Sharon Blackburn

This quiz should be used for Activity 3.8

This activity should be done in a large group if possible.

One person should act as quizmaster. The quizmaster should read out the following questions without referring to the answers.

When everyone has jotted down their answers, the quizmaster should ask people in the group what they thought was the right answer to each question in turn and what their reasons are. After discussing each question, the quizmaster should read out the ideal answer from the next page.

1.	A Care Plan is an Action Plan.	**TRUE OR FALSE?**
2.	A Care Plan should tell the carer what the resident's abilities are and what care is needed.	**TRUE OR FALSE?**
3.	A Care Plan, once written, does not need re-writing!	**TRUE OR FALSE?**
4.	A Care Plan should describe the Service being provided.	**TRUE OR FALSE?**
5.	The resident is entitled to continuity of Care.	**TRUE OR FALSE?**
6.	A Care Plan is written 'evidence' for Registration, and Care Managers from Social Services.	**TRUE OR FALSE?**
7.	As long as people get the Care, we don't need to document it as well!	**TRUE OR FALSE?**
8.	The Care Plan has nothing to do with the 6 Principles of Care.	**TRUE OR FALSE?**
9.	Only Care Supervisors can do the Care Plans and daily write-up on the resident.	**TRUE OR FALSE?**
10.	Care Planning takes up too much time.	**TRUE OR FALSE?**

CARE PLANNING QUIZ - ANSWERS

1. **TRUE** A Care Plan is a written down plan, to enable staff to give planned care to each resident.

2. **TRUE** Each resident has abilities. These do not disappear on entering a home. Each resident is individual. Therefore abilities differ, as will their Care needs.

3. **FALSE** A Care Plan is not a static document, because people are not static. Evaluation and reviews should be planned and ongoing so as to reflect each individual.

4. **TRUE** A Care Plan is written 'Evidence' of the service being provided, for all who have access to the documents especially Registration and Care Managers from Social Services.

5. **TRUE** The resident is fully entitled to expect continuity of Care, even when given by a different person. It is their right and a service is being purchased either directly by the resident or on their behalf.

6. **TRUE** We need to demonstrate that the Care being received by the resident and therefore provided by the staff is in a written format for Registration and Care Managers from Social Services.

7. **FALSE** What tends to happen is that staff react to situations, rather than planning the work. This can lead to residents needs being overlooked. Documented Care = Planned Care.

8. **FALSE** The 6 Principles of Care not only need to be practised but demonstrated in the written documentation.

9. **FALSE** This may be common practice. All staff can make entries on the daily record sheet. Care Assistants may be involved in writing the Care Plan.

10. **FALSE** Initially writing a Care Plan may be time consuming, BUT because it plans the work, it allows an organised/systematic approach that ultimately will create more time.

We would like to express our gratitude to Sharon Blackburn for permission to use this quiz.

PLANNING CARE & ADMISSION TO A HOME

Project Suggestions

Project 3.1 PRE-ADMISSION PROCEDURES

The pre-admission assessment has two aims: to ensure that the potential resident is fully informed about the home; to ensure that the home can cope with the individual without diminishing the care provided to others. Review the last three admissions into your home in respect to:

Information

- what information was provided to the person?
- was the information helpful?
- what additional information would the person have benefitted from?

Evaluation of the person

- Did the pre-admission assessment provide a useful guide to the abilities and needs of the Resident?
- What impact has the resident had on:
  - the overall organisation & delivery of care in the home
  - the "atmosphere" of the home
  - the other residents

Project 3.2 SLEEPING ARRANGEMENTS

People have different preferences for their sleeping arrangements. Look at how different people might sleep differently. Do they like it to be: cooler/warmer; noisy/quiet; windows open/shut; harder/softer beds; dark or light; blankets or duvet; nylon/plastic/cotton sheets?

Note down your own personal preferences on each of these points, and then find out from residents what their preferences are. Make a list of all the different preferences a person might have.

Now consider and discuss the following questions:

- Is there much difference between different people?
- What choice is available to a new admission on all of the different points?
- Would your home be able to deal with your personal preferences?
- How well has your home accommodated the preferences of residents?

Project 3.3 **BROCHURES**

Ideally, this project should be done in 2 small groups.

Group 1: Devise a simple brochure for the Home, listing the 12 key points to get across to potential clients and their families.

Group 2: Ask the residents what they like and what they feel they needed to know about the home. Then draw up the 12 key points of the brochure based on this information.

Both groups: After devising your two separate "brochures", get together and compare the lists and consider the following issues:

- Do staff really know what is important to residents?
- What would you yourselves want to be sure about? Do residents' responses fit in with this?
- Does your home have a brochure? If so, does it need to be changed in the light of what you have discovered? (If not, are you now in a position to have one?)

Project 3.4 **THE ROLE OF STAFF**

The admission period can be very difficult for some new residents and it is up to the staff in the home to help the person to make the transition into continuing care. Explore how each grade of staff can contribute to making new admissions feel welcome and comfortable, and make a list of your suggestions.

Talk to some of your residents and find out their views. You could include the following different members of staff:

Catering

Gardener/Handyman

Housekeeping/Laundry

Manager/Administration

Night Staff

Nursing & Care Staff

Relatives/Friends/Volunteers

Project 3.5 THE TRANSITION INTO CARE

It is important to understand the admission process from the point of view of the new resident. Talk to residents who have recently been admitted, their relatives, friends, etc. and answer the following questions:

- Why it was felt that admission into a care home was necessary?
- What did they feel about the things or people they left behind?
- What were the things that they looked forward to?
- What were their fears or the things they did not look forward to?
- What impact has admission into care had on the resident's lifestyle?
- What impact has it had on the lives of the carers?

N.B. Agree within the home who will talk to which residents. It is important to approach this subject sensitively and not to have too many people asking the same questions, as this will make the new residents and their families feel **very** uncomfortable!

Project 3.6 RESIDENTS WITH DEMENTIA

To make the transition from what they think of as home to a strange place is hard enough to cope with if it is made with full understanding. If clients with dementia don't know **why** they made the move, or have a firm understanding of **where** they are now, then this will make settling in very difficult. Consider the case of demented residents you know well, or try speaking to residents in your home and ask them:

- if they know where they are?
- what was their previous address?
- why they think they are here?

Project 3.7 MONITORING CHANGE

It is important to monitor a resident's progress over time, because care plans have to change as a resident's needs and abilities change. For this project, choose a group of residents that you know well. Firstly, without reference to the case notes, try to assess how each one has changed over the time since they have been a resident.

Do this in terms of:

- mobility
- mental functioning
- behaviour
- mood
- activities of daily living - washing, dressing, eating, toileting, etc.
- health
- overall well-being

Now use the case files to look at how the same residents have changed over time in the same areas (if you are doing this project in a group, swap over residents between you so that you are assessing someone you don't know so well). Then answer the following questions:

1. Do you have enough of the right sort of information in the case files to allow you to make these assessments of a resident?

2. Could staff who don't know the resident so well (eg a new member of staff) be able to use the information in the case files to get a good picture of how that resident has changed over time?

If you said yes to question 1:

- What (if any) are the differences between the two assessments you have made for each resident?

- Which is a more reliable way of monitoring a resident - case notes or your memory? Why is this so?

If you said no to question 1:

- What information is lacking in the case files?

- Why do you need this information?

- What do you need to do to collect this information?

Project 3.8 **PRIORITY CARE PLANNING**

The priority care plan can be used to outline the special care that a resident must have to avoid a serious breakdown in their health or welfare. It is mainly used for:

i. residents whose **ongoing needs will always remain a priority**, because if those needs weren't met day to day they would suffer a serious breakdown.

ii. a shorter period to deal with a resident who is **going through an acute phase** of illness or a temporary emotional or behavioural problem.

Choose 2 or 3 residents who have recently been in either of these categories and answer the following questions:

- What were the particular problems or needs of these residents?
- What special care was required by them?
- If priority care planning is practised in your home, describe the problems that could have occurred without priority care planning.
- If priority care planning is not practised in your home, in what ways could this have helped in caring for these residents?

Project 3.9 **RESIDENT DIARIES**

The daily diary is used to record the ongoing welfare of the resident and staff activity in respect to the care plan. The daily diary should be tied in with the aims and activities laid down in the care plan. It should also mention any other aspect of the resident's welfare that is relevant to their care.

Look at resident diaries that are kept in your home. Are these diaries really useful? Are they being kept properly? Consider the following questions:

1. do the diaries show how a resident is being cared for?
2. do they provide daily information to help with further assessment of the resident's needs?
3. do they check that care activities in the care plan have been done?
4. are they accurate and based on real facts and evidence rather than just opinions?
5. do they mention achievements as well as problems?
6. do they highlight where things are going right or wrong with a resident?
7. can you suggest any improvements for the resident diaries in your home?

Project 3.10 QUALITY OF LIFE OR QUALITY OF CARE?

We shouldn't see care just as a set of tasks which are "done to" a resident. Instead of the usual practice of building care around their disability, we must ask how we can help a person to continue their lifestyle, to achieve their best quality of life, taking into account any abilities and disabilities.

Choose two or three residents that you know well and review the care that is being provided for them:

- what are the needs and preferences of each of the residents?
- what things are important to each of the residents?
- what makes them feel happy or good?
- what are the main areas of concern for each of the residents?
- what are the things that spoil or interrupt the person's lifestyle and quality of life?
- what are the residents' expectations about themselves and what do they want the care provided in the home to achieve?
- is the care provided in the home really giving them the best quality of life?
- is there anything that could be done to meet their needs and preferences better?

PLANNING CARE & ADMISSION TO A HOME

Background Material

This is a list of background material for Unit 3. As in the first two units, it has been divided into 2 sections. The first section is recommended for everyone to do. Section 2 is more advanced information, for people who already have more experience in this area, or who would like to go into it in more detail.

Section 1 **Recommended for all students:**

Book: Section 2.1 "Admission Procedures", *"Home Life: A Code of Practice for Residential Care"* (London: Centre for Policy on Ageing)

Book: Chapter "The Care Assistant's Role" pages 48-68, *"Taking Good Care"* (Jenyth Worsley, Age Concern England) [especially the section on *"Admission of a new resident", pages 52 - 56.*]

Book: *"From Home to a Home"* (Counsel and Care)

Cassette: "A Cream Cracker Under The Settee" from *"Talking Heads"* (Alan Bennett, BBC Radio Collection)

Booklet: "The Admission Process" Booklet 1, *"Home Work: Meeting the Needs of Elderly People in Residential Homes"* (Judith Hodgkinson, Centre for Policy on Ageing)

Booklet: "Residential Living: Lifestyle or Life Sentence?" Booklet 2, *"Home Work: Meeting the Needs of Elderly People in Residential Homes"* (Judith Hodgkinson, Centre for Policy on Ageing)

Handout: *"Are Homes 'Homely'?"* (Dr Andrew Sixsmith, Institute of Human Ageing)

Handout: *"Elderly People in Residential Care"* (Dr Andrew Sixsmith, Institute of Human Ageing)

Book: *"Homes are for Living In"* (Social Services Inspectorate: HMSO)

Section 2 **Advanced level:**

Alan Bennett — *"A Cream Cracker Under the Settee"* (Transcript) In J. Johnson & R. Slater **Ageing and Later Life**, pages 38-46. London: Sage (1993).

Department of Health & Social Services Inspectorate — **Care Management and Assessment : Practitioner's Guide.** London: HMSO.

A. Norman — **Rights and Risks.** pages 14-28. London: Centre for Policy on Ageing (1980). [Also in J. Johnson and R. Slater (1993) **Ageing and Later Life**, pages 137-143].

M. Oleson & K.M. Shadick — *"Application of Moos and Shaefer's (1986) Model to Nursing Care of Elderly Persons Relocating to a Nursing Home"* Journal of Advanced Nursing 18(3) pages 479-485 (1993).

National Institute for Social Work — **Residential Care: The Research Reviewed.** London: HMSO (1988) [especially chapter *"Reasons for Application and Admission" pages 257-265.*]

J. Neill — **Assessing Elderly People for Residential Care : A Practical Guide.** London: National Institute for Social Work.

E. Steinfield — *"The Place of Old Age: The Meaning of Housing for Old People"*, In J.S. Duncan (ed) **Housing and Identity**. New York: Holmes and Meier (1982).

D.M. Willcocks, S.M. Peace & L.A. Kellaher — **Private Lives in Public Places.** London: Tavistock Publications (1987). [especially Chapter 3 *"Crossing the Threshold".*]

P.J. Youll & C. McCourt-Perring — **Raising Voices : Ensuring Quality in Residential Care.** London: HMSO (1993).