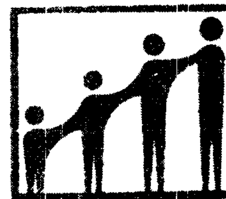
# THE Institute of Human Ageing



# THREE EXPERIMENTAL HOMES FOR THE ELDERLY MENTALLY ILL

## FINAL REPORT

J.R.M. Copeland, C. Crosby,
A.J. Sixsmith and J. Stilwell

The University of Liverpool
PO Box 147
Liverpool L69 3BX
United Kingdom
Tel. 051-794 5074/7

# THREE EXPERIMENTAL HOMES FOR THE ELDERLY MENTALLY ILL

## FINAL REPORT

J.R.M. Copeland, C. Crosby,
A.J. Sixsmith and J. Stilwell

November 1990

Institute of Human Ageing
University of Liverpool
PO Box 147
Liverpool L69 3BX

# THREE EXPERIMENTAL HOMES FOR THE CARE OF THE ELDERLY MENTALLY ILL:

## SUMMARY OF RESEARCH FINDINGS

## Overview of the three Schemes

Against a background of increasing numbers of elderly mentally ill people, the Department of Health established an initiative to develop and evaluate alternative ways of caring for this client group. Three experimental schemes were established, with the Department providing 50% funding for five years. All three units aim to provide a homely and domestic living environment and provide individualised care for clients.

Highgrove House, High Wycombe, opened 1985: Highgrove provides residential care for 17 residents and assessment and relief care for a further three. It is a joint scheme between High Wycombe Health Authority and Buckinghamshire Social Services, but is run on a social services model. Highgrove caters primarily for people who have been classed as managerial problems and is set up to provide an alternative to long-term psychogeriatric care.

Redcourt, Liverpool, opened 1986: Redcourt provides permanent residential care for 23 elderly people with severe dementia, but not suffering from other significant physical illness. Older people suffering primarily from functional psychiatric illness are catered for by other local psychogeriatric services. Redcourt functions as an independent nursing home within Liverpool Health Authority.

Seward Lodge, Hertford, opened 1987: Seward Lodge contributes to East Hertfordshire Health Authority's strategy for providing a localised service for the elderly mentally ill. It functions as an independent nursing home, providing 20 permanent residential places, 4 relief care beds and day care for up to 15 people each day over a seven day week. A "total-care" approach is employed, where nursing staff have a generic role and are involved in all aspects of direct and indirect client care and hotel tasks.

## Resourcing the three schemes

All three schemes were highly resourced in terms of staff. A psychiatric ward, included as a comparison had only three-fifths the number of staff of Highgrove and Seward Lodge. Redcourt had the highest ratio of qualified staff to residents (0.51), with Highgrove and the psychiatric ward having similar numbers of qualified staff (0.43 and 0.39). Seward lodge had the smallest qualified staff to client ratio (0.35 for residents and 0.23 for day attenders).

In comparison with conventional hospital wards, there was a substitution of untrained for trained staff in respect to direct client care at Highgrove and Seward Lodge.

The use of generic workers at Seward Lodge is probably cost-effective, but was not a popular option amongst staff.

## Economic aspects of the homes

No direct relationship was found between dependency (as measured by standard instruments on physical condition, mental functioning and tasks of living) and the way staff resources were distributed amongst residents. This has implications for the way nursing homes are funded as current mechanisms may not reflect the actual "demandingness" of clients.

The extra resources available within the Homely Homes were largely channelled into routine care, such as resident hygiene, dressing and feeding. The extra resources produced only a limited return in terms of "positive", life-enhancing care, such as social interaction with residents and activities. Daytime resources were doubled, but only resulted in a twenty-five percent increase in positive care.

The relative failure to deliver positive care in line with extra resources is difficult to explain. However, the indications are that this is not due to the substitution of untrained for trained staff, but rather related to other issues such as the difficulty in sustaining positive activities with this client group.

The research showed that the use of activity organisers or occupational therapy aides did result in higher levels of positive care. With clients with dementia, a care model which includes a considerable amount of task assignment stands a greater chance of maximising positive care than one which relies on personalised care alone.

## Staffing issues

There is no evidence that the use of largely unqualified care staff to provide direct care resulted in any detriment to residents.

Both Highgrove and Seward Lodge devolved responsibility for individual client care to unqualified staff. Unqualified staff were designated as keyworkers with responsibility for the development and implementation of client care plans. There is no research evidence to suggest that clients were disadvantaged by this. However, considerable emphasis is required in respect to management support, in-service training, quality assurance procedures and staff recruitment policy.

Although based on a social services model of care with no direct nursing input, Highgrove was able to cope with residents with behavioural problems who would normally have been admitted to long-stay psychiatric or nursing care.

## The physical environment

Highgrove and Redcourt are buildings converted from other uses. Both are problematic in terms of the physical environment. At Highgrove, there is a general lack of space, while resident accommodation at Redcourt is on two floors. Seward Lodge is a single-level purpose-built unit and provides excellent amenities, high space standards and a varied living environment.

All three homes provided a more domestic and homelike living environment than is commonly found in residential care settings and long-stay hospital wards in particular. The homes offered high levels of private space and encouraged independent behaviour amongst residents.

However, residential accommodation based on communal living is invariably "unhomelike". Long corridors, offices and large communal lounges were features that are not found in truly domestic environments.

Individual bedrooms were used very infrequently by residents. Many residents were unable to find their own rooms, while the design of Redcourt and Seward Lodge did not encourage residents to use their own rooms. With

the exception of Highgrove, the care regimes were geared towards communal living.

All three units are in somewhat isolated locations, restricting social integration.

Quality of life issues

Conceptual and methodological problems: Measuring "quality of life" is particularly difficult with this client group because they are generally unable conceptualise their needs or to express their feelings and attitudes. Existing concepts and measures of quality of life in residential and nursing home settings reflect the needs of the physically frail rather than the mentally impaired.

Relatives' views: Relatives were interviewed as advocates of the residents. Their response to the three homes was very positive. Residents were seen to be happy and settled in the three units, while day attenders at Seward Lodge gained benefit from a change of scene and the company of others. Relatives felt that the standard of care was high and that staff had a very caring attitude.

Pattern of daily life: The pattern of daily life in the three homes was relatively unstructured. Rather than making residents fit an institutional routine, the Homely Homes provided flexible regimes that accommodate the varying needs and propensities of individual residents.

Community links: Admission to the three homes, and to long-term care in general led to the disengagement of residents from their families and wider society. In this sense, the three schemes are still very much in the traditional pattern of old peoples' homes.

Autonomy: The research showed that beyond being able to feed themselves, residents were typically able to do very little in terms of self-help. Residents' abilities to do things for themselves is limited by their mental functioning. However, the effect of "learned dependency", that is associated with institutional environments, was also a limiting factor.

Choice: A lack of insight and understanding meant that residents were often unable to exercise choice in a conventional sense. In this context, the role of the keyworker is important in understanding and meeting the needs of individual residents.

Lifestyle: Although the experimental homes aimed to provide a better quality of life for residents, positive aspects of lifestyle, such as leisure and social interaction was found to be no higher than in conventional long-stay psychiatric wards. The most common use of time by residents was "doing nothing". Moreover, "disengaged" activities, such as doing nothing, dozing, wandering or disturbed behaviour accounted for a majority of residents' waking time (60%), while purposeful, engaged activities such as social interaction, independent and dependent self-help and leisure accounted for a much smaller proportion (40%).

Outcomes of Care

Survival: Although the research data only allows tentative conclusions about survival, all three schemes had low death rates. Moreover, at Seward Lodge

there was much higher death rate for day attenders (58.6%) compared with residents (23.8%) over a two year study period, even though residents were generally frailer and more dependent. The indication is that the protective and specialist residential environments afforded by the homes promote the longevity of residents.

Psychological Well-being: Psychological well-being is very difficult to define and measure for people who are cognitively disordered. However, some residents appeared to benefit or improve in terms of emotional well-being, agitation, aggression and cooperation. This suggests that those people who have psychological, behavioural or psychiatric disorders, as well as cognitive impairment, are likely to benefit most from the sort of care provided by the three homes.

Dependency: Overall, clients exhibited a pattern of gradual deterioration over time in respect to physical condition, cognitive functioning, and daily tasks of living. However, this general picture hides considerable individual differences. In particular, a number of residents initially improved in terms of cognitive functioning and tasks of daily living after admission to Highgrove House, although these levels subsequently deteriorated over time. These were people who exhibited psychological or behavioural problems on admission and who were seen to benefit from individualised care and a reduced level of medication

Benefits to Relatives: Relatives of residents expressed a very high level of satisfaction with the homely homes. The benefits to relatives were: relief from constant worry; relief from the task of continuous caring; knowledge that the relative is well cared-for. This last point is important in ameliorating the sense of guilt that a person often feel when their relative is admitted to care.

## ACKNOWLEDGEMENTS

We would like to thank the representatives and staff of East Herts Health Authority, Liverpool Health Authority, Wycombe Health Authority and Buckinghamshire Social Services Department for their cooperation and help.

We are particularly grateful to the management and staff at Highgrove House, Redcourt and Seward Lodge for their commitment to the research and active assistance and support during the evaluation.

We also acknowledge the clients of the three homes and their relatives for their patience and generosity throughout the project.

# CONTENTS


| | | Page |
|---|---|---|
| Chapter 1. | INTRODUCTION | 1 |
| Chapter 2. | METHODOLOGY | 3 |
| Chapter 3. | OVERVIEW OF THE THREE EXPERIMENTAL HOMES | 6 |
| Chapter 4. | THE NEED FOR SERVICES | 16 |
| Chapter 5. | STAFF ACTIVITY STUDY | 21 |
| Chapter 6. | THE CLIMATE OF CARE | 34 |
| Chapter 7. | OUTCOMES OF CARE | 56 |
| Chapter 8. | CONCLUSION | 71 |
| | REFERENCES | |
| | APPENDIX | |

# CHAPTER 1: INTRODUCTION

The "Rising Tide" is the name given in 1982 by the Health Advisory Service to the increase in the number of people suffering from senile dementia. As the proportion of the population who are elderly grows, so will the number of people with dementia, increasing their demand upon the caring services. The response to the Rising Tide is not just a matter of more services, but also a question of what sort of services should be provided. Particular interest has focused on how to improve care for those people who are not so mentally impaired as to need continuing hospital care, but whose disabilities would be regarded as too great for a local authority home; the 'too fit and too frail' syndrome. Such people have often been placed in expensive and inappropriate hospital accommodation, because there have been no specialist residential homes locally available (Copeland, 1984; De Zoysa and Blessed, 1984).

It is against this background that the Department of Health (DoH) established an initiative to develop and evaluate alternative ways of caring for elderly people, suffering primarily from psychiatric and cognitive disorders. The DoH has provided 50% of the funding for experimental homes for a period of five years, the balance to come from local health or social service funding. From a number of proposals, three schemes were chosen:

Highgrove House, High Wycombe

Redcourt, Liverpool

Seward Lodge, Hertford.

As experimental units, each has been closely monitored by an evaluation team based at the Institute of Human Ageing, University of Liverpool, on behalf of the Department of Health. The evaluation has a number of broad aims:

-To describe the operation of the three schemes

-To assess for each scheme how far its practice achieves its own operational criteria

-To determine the appropriateness of the schemes to the service needs within each District

-To make comparisons between the schemes and with existing services

-To draw general conclusions about the setting-up and operation of the units

It was recognised that the evaluation of the three schemes would be largely descriptive, although there would be a quasi-experimental element to it in that some comparison would be made between the units and with existing services. The DoH emphasised that this was the kind of study it was seeking rather than full-scale experimental research. Illsley (1980) makes a distinction between different approaches to evaluation and the kinds of results they produce. 'Process data' relates to the way in which the service is being provided and 'outcome data' relates to the effects of the service on clients. Descriptive and quasi-experimental evaluations will provide data about the process of patient care, but only true experimental research can afford firm conclusions about the outcomes of services for clients. Nevertheless, it was felt that some indications of outcome could be suggested for the three schemes, although the thrust of the research would remain descriptive.

The research protocol (Crosby, 1985; Copeland et al, 1986) has been revised during the course of the evaluation and a number of changes in emphasis and procedure have been made to reflect changes in the context in which care is provided. It is recognised that there have been considerable changes in national and local policy on the role of the public sector in respect to long-stay care provision for elderly people. The 1980s saw a tremendous growth in private sector provision. Already many Health Authorities throughout the country have reduced their level of direct provision of continuing care, often through the transfer of responsibility to voluntary organisations. Indeed, one of the experimental units described in this report will achieve independent status as a charity in December 1990. In general, the role of public sector agencies will shift from that of direct provider to facilitator. In the light of these changes, the evaluation has given less attention to the processes by which the three units were set up and more attention to the broader issues arising from the research. Two themes of <u>resources</u> and the <u>quality of life</u> of residents are central to the present report.

The initial research proposal was augmented at the DoH's suggestion to include 2an economic analysis of each scheme. The financial aspects of care provision are a primary concern and this is reflected in the report, where considerable attention is given to the way resources are utilised and allocated within the three schemes.

The evaluation has also focussed on the issue of quality of life of residents. It is important to make the distinction between quality of care and quality of life. Evaluations have tended to focus on the former as a measure of the worth of a particular project. However, high quality care in a nursing home does not necessarily mean a high quality of life for the residents. Indeed, if that care is inappropriate to the needs of the individual, then a poor quality of life is the likely result, whatever the actual "standard" of provision. Thus, it is important to look at the outcomes of care for residents and also at the overall 'climate' or 'atmosphere' that exists within the units.

## CHAPTER 2: METHODOLOGY

In the context of this report, it is not possible to describe the research methodology in detail. Readers who require full accounts of the various instruments used during the course of the study should consult the original project protocol (Crosby, 1985) and a number of individual reports that describe specific components of the evaluation. Many of the research instruments were drawn from other studies and these are referenced where appropriate. Further details of research methods are also given in the individual chapters within this report. The rest of this section briefly describes the various research procedures undertaken during the evaluation.

Client dependency: The dependency of individual clients was assessed using the Clifton Assessment Procedures for the Elderly (CAPE) (Pattie and Gilleard, 1978) and the modified Chrichton Royal Behaviour Rating scale (Wilkin and Jolley, 1979). These provide data on physical and mental functioning, ability to perform tasks of everyday living and behavioural problems. Assessments were undertaken on a three-monthly basis from admission to the end of the fieldwork stage, providing longitudinal data on over 100 clients' progress over a period of between four years and six months. The case notes kept by staff in the homes also represented an important data source. This was mainly qualitative data, which added greater detail and insight to the quantitative assessments.

Staff opinions and attitudes: As "insiders", the views of the staff in the three homes were a prime data source, providing information on individual residents and care practices within the homes. Staff views were elicited through self-completion questionnaires and in-depth interviews.

Views of relatives: The views of relatives were important on two counts. Firstly, relatives provide an alternative perspective for evaluating the quality of life of residents. As most residents were unable to express opinions, relatives were used as advocates to provide a consumer perspective. Secondly, relatives are themselves "clients" in that they may directly or indirectly receive benefit from the service. This was particularly the case at Seward Lodge, where short-term admissions were aimed at giving relatives relief from the task of caring. Approximately 100 relatives were contacted during the course of the research and their views were elicited using in-depth interviews or self-completion questionnaires.

Senior Personnel Interviews: Interviews were conducted with senior staff outside the three homes, including senior representatives of local health authorities and social Services departments, consultant psychogeriatricians and nursing officers. The level of involvement with and knowledge of the homes varied considerably and interviews were conducted on an informal basis using an agenda of discussion topics, rather than a structured questionnaire.

Staff activity analysis: A key aim of the research was to examine the way staff resources were used in practice, both in terms of the level and nature of the care that was being provided and how this varied in relation to different staffing levels within the homes. The activity study involved the development of a new instrument, based on diaries completed by all staff over a full week. The week was divided into quarter-hour periods and staff were asked to describe what they were doing in each period. Interactions with clients were classified in terms of demanding, routine and "positive" care. Demanding care is any intervention that has to be undertaken immediately at the expense of other forms of care, such as dealing with

accidents or aggressive behaviour. As the name implies, routine care is the day to day tasks of supporting clients. Positive care refers to any intervention that is aimed at enhancing the quality of life of the client and is of particular interest in the context of the present study. Other actions which did not involve direct client care were classified as 'task', 'administration', 'break' and 'observation'.

Observation study: The observation study was a means of providing a detailed record of all activity within the homes. The observational approach is less subjective than the self-completion diary approach and also allows for richer and more complex data to be gathered. Observational research, however, is more researcher-intensive and fewer data items are generated. For the purposes of the observation study, a new instrument was developed. The working day of two shifts was divided into half-hour periods and activity data for all individuals (clients, staff and visitors) within the home was collected by an observer for each period. Data collected included: location of individual within the home; what they were doing; interactions with other individuals; the nature of any speech. If the subject was a member of staff, details of whether they were providing direct client care were recorded and whether interventions were demanding, routine or "positive". If the subject was a client, observable signs of state-of-mind (sadness, irritation and anxiety), were also recorded. As well as providing information in its own right, the observation study was also used as a means of validating the diary-based activity study.

Evaluation of the Social Environment: The social environment of the three homes was evaluated in a number of ways. Much of the observation study was devoted to issues such as the day-to-day patterns of living and social interaction. A specific research tool, the Institutional Regimes Questionnaire (IRQ), was also used. This was developed by Booth (1985) to describe the institutional framework within which residents live. The IRQ focussed on four dimensions of the social environment within the homes: personal choice; privacy; segregation; and participation.

Evaluation of the physical environment: The focus of this part of the evaluation was on the "homeliness" of the three units. The instrument used was an architectural checklist devised by Robinson and associates (1985) that distinguishes between homely and institutional characteristics on a range of design items related to site building and layout.

"Informal" data: The intensive nature of the evaluation afforded the researchers considerable day-to-day contact with the experimental units. This contact meant that information pertinent to the research could be collected on an informal basis through discussion, observation.

Documentation: As experimental schemes supported by the DoH, all three units actively cooperated in the evaluation project. For research purposes, all documentation was available, including client assessments, case notes, reports, minutes of meetings, local area statistics and financial information. The only restriction on access was in respect to the personal files on staff.

Comparison data: It was not possible to utilise an experimental methodology. For example, a randomised control sample of clients could not be set-up as decisions about referrals and admission were taken locally, without reference to the evaluation. However, it was felt that some comparisons should be made between the three homes and other establishments, particularly in respect to issues such as the utilisation of staff resources and the social and physical environment. Data on resident dependency, the physical

environment, and the social regime were collected for Part III homes in Buckinghamshire and also for a long-stay psychogeriatric ward in a large psychiatric hospital. Observational data were also collected on a three psychogeriatric wards in hospital settings.

# CHAPTER 3: AN OVERVIEW OF THE THREE EXPERIMENTAL HOMES

This chapter provides basic details about the three homes, covering issues such as the philosophy of care, admissions procedures and the physical environment. Each home is described in turn. This is followed by an analysis of the costs of the homes in relation to a number of care strategies for the elderly mentally ill. The three experimental units are:

Highgrove House, opened in January 1985 in High Wycombe, Bucks

Redcourt, opened in April 1986 in Liverpool

Seward Lodge, opened in April 1987 in Hertford.

## HIGHGROVE HOUSE

Highgrove House is a jointly funded scheme between Wycombe Health Authority and Buckinghamshire Social Services. Care is based on a social services residential model and staffed by multi-professionals from the Health Authority and Social Services Department, working as a team both within the home and the community. The objective is to provide care for those whose needs have not easily been met through existing services. Highgrove provides continuous, permanent care for 17 residents, and a further three places for shared and relief care for elderly people who are not so disturbed as to require continuous hospital care, but whose behaviour is regarded as too difficult to manage in local authority homes.

### Philosophy of Care

Highgrove is divided into two group living units of ten residents each. As far as possible, staff work on the same unit, in order to provide consistency and continuity of care. This together with a keyworker system is aimed at minimising restrictions on residents and maximising personal choice. The objective is to allow residents to follow their own "natural" daily routines and there are no specified times for getting up or going to bed, although there are set meal times. Although residents are encouraged to follow the typical pattern of group living, the philosophy is that they should not be constrained to do so. Within this basic context, the specific needs, abilities, problems and potential of the individual resident are addressed by a keyworker utilising a detailed care plan.

### Admissions and Assessment

Requests for admissions come from a variety of sources: general practitioners, social workers, community nurses, hospitals, residential homes for the elderly, etc. All clients are assessed by a multidisciplinary team attached to Highgrove. Some may have already undergone psychiatric assessment, but a further assessment of the social and emotional needs of the individual and their family is undertaken. Assessment includes initial assessment in the client's own place of residence, followed by a period of up to four weeks at Highgrove House.

## Admission Criteria

Residents are drawn from people living in the community and from people already in some form of institutional setting. Residents include older people who have some form of dementia and/or psychiatric illness or psychological dysfunction. The key admission criterion is that the individual presents some form of behavioural problem that could not be managed in a conventional residential home. This includes: people who are restless, aggressive, agitated, or wanderers; people who exhibit socially unacceptable forms of behaviour, such as being excessively noisy, or smearing faeces; individuals considered awkward personalities.

## Management Structure

Overall management responsibility is vested in a Joint Management Team, comprising two senior officials from both the Health Authority and the Social Services Department, the Consultant Psychiatrist, representatives from both Treasurers Departments and the officer-in-charge of Highgrove. Day-to-day management is delegated to the officer-in-charge, who is supported by a senior team of residential social workers, including a deputy officer in charge and two assistants. Staff are employed by Buckinghamshire County Council, and the officer in charge is accountable to the Principal Homes Manager.

## The Care Team

Each resident has their own key-worker, and individually designed care plans are produced, which are regularly reviewed. The team of residential social workers, providing direct care in the home, is assisted and supported by a multidisciplinary team comprising a consultant psychiatrist, a visiting medical officer, an occupational therapist, a physiotherapist, and a speech therapist. It was also intended to appoint a clinical psychologist, but it was not possible to fill this post. A professional domiciliary team of a community psychiatric nurse and a social worker, provides support to clients and their relatives in the community, particularly those receiving relief care at Highgrove. The team is involved in developing practice procedures in Highgrove, including assessment and treatment programmes in order to cope with problems of acute agitation, hyper-activity, wandering and confusion.

## The Home

Highgrove is situated in High Wycombe in a former General Practitioner maternity unit, which has been fully refurbished to provide a homely atmosphere for sixteen permanent residents. The building is located on a site that is also shared by the Health Authority headquarters and the Department of Mental Health of the Elderly (DMHE). Highgrove is located on a steep hill above the centre of High Wycombe, making pedestrian access difficult. The site itself is sloping making steep steps and ramps necessary for access from the building to the garden. The garden is a small grassy area enclosed by a wooden fence. Most residents have their own rooms, although four of the residents share double rooms. There are four places which can be used for relief or emergency care. The home is in two wings, each with its own living room and dining facilities. Residents are able to bring their own furniture and personal

possessions and decoration of the rooms is individualised. The aim is to encourage residents to regard their own rooms as their home-base. Highgrove originally relied on health authority catering, but on-site catering has since been established.

Care of Residents

A "key" residential worker is responsible for a person's care within the home. Residents have individually designed care plans to suit their specific needs, developed at the time of the first assessment. Care plans are reviewed four weeks after admission and then updated during staff meetings and a annual multidisciplinary review of the client's progress.

Education and Training

An objective of the Highgrove scheme is to develop the skills of staff working with the elderly in other settings and locations. Highgrove offers support to local GPs, private and voluntary homes, hospitals and other local authority residential homes. A programme of seminars and conferences has been developed to cater for this and for internal training purposes. This includes courses such as "Working with elderly mentally infirm people" and "Communicating with elderly mentally infirm people".

Community Involvement

A league of friends has been set up and is supported by the Lord Mayor of Wycombe. The Friends have helped in fund-raising, recruiting volunteers and assisting residents. When an individual becomes a permanent resident, they retain their own General Practitioner if they wish. Residents requiring professional nursing care are visited by the community nurse. Any hospital admissions are arranged by their General Practitioner, and their place at Highgrove is kept for them. Spiritual needs are met by arrangements with local ministers of religion. Relatives and friends of residents are able to visit at any time and an objective is to encourage them to take part in activities and events.

Monitoring and Self-Assessment

Internal monitoring and evaluation within Highgrove covers three main areas: the progress of individual residents; staff supervision and performance; and the evaluation of the units overall performance. The progress of residents is monitored by means of the detailed care plan and an annual review. A resident's progress is discussed at each shift handover meeting and during staff meetings. Any specific needs or problems are assessed on an ad hoc basis. For example, agitation or mood changes can be charted over time. Staff are assessed by means of individual and group supervision and in senior staff meetings. New staff are given a probationary period of six months and all staff are annually appraised. At an organisational level, an establishment review is undertaken and overall progress is regularly reviewed in senior staff meetings.

**REDCOURT**

Redcourt provides permanent residential care for 23 elderly, severely mentally infirm people who required continuing care in a non-institutionalised domestic setting.

## Philosophy of Care

The expressed aim of Redcourt is to provide a warm, comfortable, homely atmosphere, which will promote individuality, self-respect, dignity, privacy and self- determination. Management also emphasise the need to create a stimulating environment which encourages the residents to achieve and maintain their maximum potential and to retain a sense of worth and identity. Three basic values are stated as essential to good care: that residents are entitled to basic respect and dignity as individuals; that individuals should be enabled to achieve their maximum potential; that relatives should be welcomed as participants in care.

## Admission Criteria

Within the framework outlined in HM(72)71, Redcourt primarily admits people with severe dementia, but not suffering from other significant physical disease or illness. Elderly patients with functional psychiatric illness receive treatment from elsewhere within the Health Authority.

## Management Structure

Redcourt operates as an independent nursing home within the local health Authority, in that it manages its own budget and is responsible for its own internal policy and day to day running. The home manager has overall responsibility and is supported by a deputy manager and a hotel services manager. Clinical care, standards and education are the responsibility of the deputy manager. Below this, residents are split into five groups headed by a primary nurse who is responsible for the supervision of that group.

## The Care Team

The care team consists of both nursing and housekeeping staff, activity organisers, a porter, clerical officer and hairdresser. Selection of admissions and psychological aspects of care are the concern of the Consultant Psychogeriatrician. Medical care is provided by a general practitioner who visits on a regular basis. The senior nurse is responsible for every aspect of day-to-day management. The senior cook/housekeeper heads the housekeeping team.

## The Home

Redcourt is situated in the Mossley Hill area of Liverpool, some four miles south east of the city centre. Redcourt is close to Sefton Park and is situated in an area that has both residential and service use, including Mossley hill Hospital and the University of Liverpool Halls of residence. In recent years a considerable number of private nursing homes have

opened in the area. Redcourt, formerly a large private residence, then a nurses' home, has been redesigned and refurbished to provide a homely environment, without altering the original character of the building. The building is on three floors, with staff rooms and offices on the second floor. The first floor consists of residents' bedrooms, bathrooms, sitting areas and service facilities. The ground floor has a large lounge and a smaller "quiet" lounge which is also used for special activities. There are two bedrooms on the ground floor, which are generally used for high dependency residents. Overall, there are seven single rooms, three double and two rooms that accommodate four people each. There is a patio area directly next to and accessible from the main lounge. Redcourt has its own kitchen facilities and all catering is done on site.

Admissions and Assessment

Admission to Redcourt is at the discretion of the consultant psycho-geriatrician. The first residents were drawn from a long-stay ward at Rainhill Hospital. Since that time admissions have been preceded by a process of assessment by hospital and community services and multidisciplinary review. Psychiatric assessment is done prior to referral to Redcourt.

Care of Residents

A trained member of staff, known as the Primary Nurse, is responsible for the total care of 4/5 residents. The Primary Nurse is supported by associate nurses. The continuous one-to-one interaction between nurse and patient is aimed to allow the development of a close relationship with the resident. Primary nurses are also expected to develop a close relationship with the the resident's family. Nursing care is assessed, implemented and evaluated using Roper's model of nursing based on assessment of activities of daily living.

Education and Training

Much emphasis is placed on training within Redcourt itself, both in terms of Redcourt as a training resource and in terms of in-service training. Redcourt has been used as an education and resource facility at a local, national and international level. Since 1989, RMN learners from a local college of health care studies have been placed on a training programme at Redcourt. Redcourt senior staff have also developed an ENB course 941 in care of the elderly. A primary nursing development course is also offered as part of an income generation policy. In-service training is provided for both qualified and unqualified staff. Unqualified staff attend the RMN training programme, while qualified staff undertake a 2-week orientation programme.

Community Involvement

The establishment of a relatives association has been designed to allow staff and families the opportunity to meet on a regular basis. The association also allows relatives to be informed of developments within Redcourt. Staff are available to offer advice and support and to listen to suggestions.

Monitoring and Self-Assessment

The operation of Redcourt is reviewed through: monthly unit meetings of all members of the care team; weekly trained staff meetings; relatives association meetings; handover meetings three times per day. The manager of Redcourt is responsible for setting objectives and evaluating performance.

## SEWARD LODGE

Seward Lodge has been developed by East Hertfordshire Health Authority as part of their strategy for a localised service for the mentally ill. Seward Lodge comprises both residential and day-care facilities. Twenty-four beds are available for residents, twenty of which are for permanent residents and four for holiday relief care. Day care is provided for up to fifteen people each day over a seven day week. Transport to and from the unit is available through the Hertfordshire ambulance service. The unit also has its own minibus.

The Home

Seward Lodge is located on the site of East Herts Hospital on the outskirts of Hertford. Despite being on a hospital site the unit functions as an independent nursing home, although reliant on hospital catering facilities. The building has landscaped grounds surrounded by an enclosing fence. Access is via a gate with a combination lock (the combination is inscribed on the gate so that non-confused visitors can pass freely. Residents are free to use the grounds with a minimum of supervision. However, some of the more physically active have been known to climb the fence. Seward Lodge is the only one of the three experimental homes for which a new building has been purposely designed and built. Most residents have their own bed-sitting rooms. These are arranged in two wings of 10 rooms each and are aimed at encouraging independent living, communal support and company. Emphasis is very much on providing a non-hospital environment, with the decor and atmosphere reflecting this. Each wing has a kitchen dining area, a sitting room and a sitting/dining room. The day area is based on an open plan design, but includes two sitting areas and a dining area. The design is intended to be flexible and to provide places for social interaction, group activities and sitting quietly within the same general area. The central axis of the building is devoted mainly to services, administration, staff facilities and circulation areas.

Philosophy of Care

Seward Lodge is not intended to function as a short-stay assessment and treatment facility, but as a nursing home for people requiring long-term care as a consequence of their deteriorating mental health. The aim is to provide individualised and personalised care in a homely and domestic setting. A "total-care" concept has been adopted, where staff are involved in all the duties within Seward Lodge and have a generic role that includes both direct and indirect client care as well as hotel tasks such as cleaning. The daily contact in different social situations within the unit is seen to enhance and develop relationships and familiarity between staff and residents.

## Management Structure

Overall responsibility rests with the senior nurse. The senior nurse is managerially accountable to the Unit General Manager and locality managers and professionally accountable to the Unit Nurse Advisor. However, these bodies have no direct input so internal policy and management is vested in the senior nurse, who submits any changes to the above bodies for formal approval. The internal management system is hierarchical. Sisters and charge nurses are directly responsible for day to day management of clinical standards and the client care provided by care assistants. The latter are accountable to the senior sister, who acts as overall deputy, accountable in turn to the senior nurse.

## Admission Criteria

The unit is designed specifically to cater for elderly people suffering from dementia with level of confusion, disorientation or dependence warranting supervision on a day-to-day to day basis. The specific admission criteria are: aged over 65 years; resident in the Health Authority catchment area; diagnosed by a psychiatrist as suffering from dementia; generally physically fit and mobile and not being treated for any other mental health problem The client or family must be agreeable to the possibility of residential admission and should demonstrate a determination to stay as independent as possible. In addition, people with specific problems, such as incontinence, behavioural problems, communication difficulties, "awkward" personalities, stabilised health problems and reduced mobility are also considered for admission. Originally, people who showed a quality of independence were seen as the key group to benefit from care at Seward Lodge. However, this criterion appears to have been relaxed in practice in response to the need within the community. In practice, Seward Lodge has accepted those clients who have demonstrated particular problems or difficulties in their current living situations. A progressive continuum of care is the aim. Clients are not accepted on an ad hoc basis, so that people who have not been regular day attenders will not be admitted for relief care.

## The Care Team

Individualised care is provided through a key-worker system of staff deployment. Most of the key-workers are unqualified care assistants. Although, many of the staff are untrained, the management and day-to-day co-ordination of care is carried out by qualified staff with experience in both mental health and general medical nursing. Trained staff have a wider role than the care assistants, in providing more specialised care, advice, care and treatment to clients. Qualified staff also have a role in supporting, supervising and training care assistants. A full-time social-worker is also attached to the unit. All other specialised expertise is provided by community based staff, as required.

## Admissions and Assessment

Written referrals are made on standard forms available to all professionals in the district who work with the elderly mentally ill. Referral documents are screened to ensure that all required information is available and that the referral appears to be appropriate. A home assessment is then

undertaken by the senior nurse and the social worker and a decision is made as to whether the client is suitable for formal assessment. During the period of assessment at Seward Lodge, a keyworker is assigned who will take a particular interest in the case, and who will play a central role in the assessment process. Assessment of the client's specific problems, needs and abilities is undertaken in a non-clinical context, mainly through social and recreational activities. Community-based health and social services professionals are consulted where necessary. After the assessment period a full evaluation review meeting is held that includes, initial referral agency, psychiatrist, general practitioner, senior nurse, keyworker and social worker. Admission is at the discretion of the senior nurse on the basis of the evaluation.

## Care of Residents

Seward Lodge is a nursing home, though the model of care aims to require a minimum of medical intervention. Carers are expected to use their expertise and skills to maintain and enhance each individual's level of performance and quality of life. Individual care plans are devised for all clients, which are regularly reviewed.

## Education and Training

Seward Lodge does not have an identified training budget. Funding for training courses comes from the general Health Authority funds. However, some external training has been funded from savings within the overall budget. Staff do go on health authority internal courses run by the school of nursing. Formal induction training for new staff was originally provided. However, these are no longer run and new staff are trained experientially.

## Community Involvement

The social worker attached to Seward Lodge liases closely with the relatives of clients in their own homes. this includes current clients and those on the waiting list. The social worker is also involved in a community-based carers support group. There is also an active relatives support group that is involved in fundraising activities. Keyworkers are expected to develop and maintain contact with relatives.

## Monitoring and Self-Assessment

Individual residents and day attenders are continuously monitored through their own case file. Although the documentation was developed within Seward Lodge, it derives from the "nursing process". The aims are to: demonstrate that appropriate care is being provided; maintain continuity of that care; record in changes in the individual's level of functioning; provide a permanent record of progress. Clients are reviewed regularly. A day attender will be the subject of a review meeting about every six months, which includes staff, family and other professionals involved with the client. Review meetings are held less frequently for residents. Individual staff are appraised within the performance review procedure of the Health Authority. There is no formalised procedure for self-assessment at the organisational level. For instance, there is no internal annual review.

## COST CONSIDERATIONS

The three homes are relatively expensive institutions for delivering care to the elderly mentally ill. This is not surprising because they were set up in a deliberately unconstrained way. During most of the history of the project, expenditure was actually below its design level for at least two of the homes, since a combination of staff turnover and the chronic difficulty in filling certain posts, notably that of psychologist, at Highgrove, led to employment of staff below establishment. Although Redcourt was included in the cost-improvement programme of the Health Authority, it started with a very high level of non-direct-care services; ironically, the area where it aimed to make its greatest percentage savings, the anonymous budget line 'Miscellaneous Patient Treatment' in fact covers the Activity Organisers, who we conclude later give highly cost-effective care.

We are not concerned here with capital costs. There was no comparison between the set-up arrangements for the units, and no lessons which can be learned. Highgrove is a physically small conversion of hospital premises. Seward Lodge is a new free-standing building finished to a high standard. Redcourt is a conversion of a large detached three storey Victorian house, finished to an exceptionally high standard. The advantages and disadvantages of the building types are dealt with elsewhere in this report, but no information was yielded which would so overwhelmingly support one type of structure as to change policy toward the relative costs and benefits of different building, purchase or conversion strategies. The relative costs of conversion and new building depend upon the condition and prior suitability of the building to be converted, and, crucially, its opportunity cost. Redcourt was probably the least cost-effective building, but this was because of the effect of its internal geography upon staffing, and nothing to do with return upon capital expenditure, since this was not subject to the sort of constraints which would apply in a non-experimental setting.

The accounting arrangements for the three units were very different. In terms of overall 'cost statement' cost, Redcourt was the most expensive, at £335 per client week (1988/9), Highgrove at £290 and Seward Lodge at £242 (£265 over residents only). But these figures mask a mass of budgeting differences. Seward Lodge figures do not include client's food, nor kitchen staff services, nor any hospital overheads. At Highgrove a large number of figures are fairly arbitrary apportionments by the Health Authority Unit which services it. At Redcourt, some of the Health Authority allocations seem very high, in particular domestic cleaners and linen services (staff and clients at Redcourt seem to get almost three times as dirty as staff at Seward Lodge). The only figures upon the basis of which comparisons can be made are the figures for the care staff. And these figures, in fact, are the only figures which are important. If this study has generalisable conclusions, these conclusions are about the relationship between the way care is delivered, the amount of care, the degree to which professional aims are achieved, the quality of care, and client outcome. The resources to concentrate on are therefore the staff who deliver care. Maximizing the cost effectiveness of methods of catering, doing the laundry, cutting the grass and heating the rooms is irrelevant to this study; and indeed it would be absurd to undertake such a study on the basis of three small units. Care staff costs were 60% of total costs at Redcourt, 72% at Highgrove, and 84% at Seward Lodge. The later chapter on Staffing Studies (Chapter 5) follows the route signalled above.

We started this chapter by stating that the three homes were relatively expensive; Table 3.1 and Figure 3.1 provide some illustrative figures for comparison. Since many persons with dementia are maintained at home, it is necessary to include both Health and Social Security costs. The hospital and residential home figures are averaged from the costing returns of a number of Midlands health and local authorities; the composite care figures were derived by means of studies in Buckinghamshire and Worcester for approximate 'package' contents. We must stress that these figures are only approximate, in view of the different accounting conventions employed, and because we do not know how representative the practice was which we observed. Given the changes which are now taking place in the funding and organisation of community care, the cost breakdowns between the agencies may be of historic interest only. The similarity between the cost of a psycho-geriatric ward in a mental illness hospital, and the costs of the three homes, is of interest. We studied such a ward as a comparison (see the Chapter 5) and the amount of care actually delivered per patient was considerably less than the homes, although the 'stated' cost was similar.

Either large hospitals are relatively cost-ineffective, in that their overheads are disproportionately large, or the aggregate average costs conceals differences within these hospitals greater than the relative nursing staffing differences, which we have allowed for.

Making some adjustments to the cost figures for the three homes; attempting, that is, to remove the most obvious anomalies by including allowances in the Seward Lodge figures for the excluded elements of full costs, we have estimated different cost relativities, and these are shown below. However, we should stress that the significant differences are the differences in staffing levels, and in these respects the three homes are similar to each other, but very different from other forms of institutional care.

Table 3.1 Costs of different strategies of care
(approx. Oct 1988 levels) £s per week:

| Strategy | Total | NHS | Social Security | Local Authority |
|---|---|---|---|---|
| Specialist hospital incl acute care | 313 | 305 | 8 | |
| Three homes | 308 | | 8 | |
| M I Hospital | 288 | 280 | 8 | |
| NHS rotating & day care | 180-223 | 143 | 32-75 | 5 |
| CPN & Home help | 99 | 8 | 75 | 16(net) |
| L A Resident | 141 | | 35 | 106(net) |
| L A Day & Home help | 135 | | 75 | 60 |
| Private home | 75-230 | | 75-230 | |

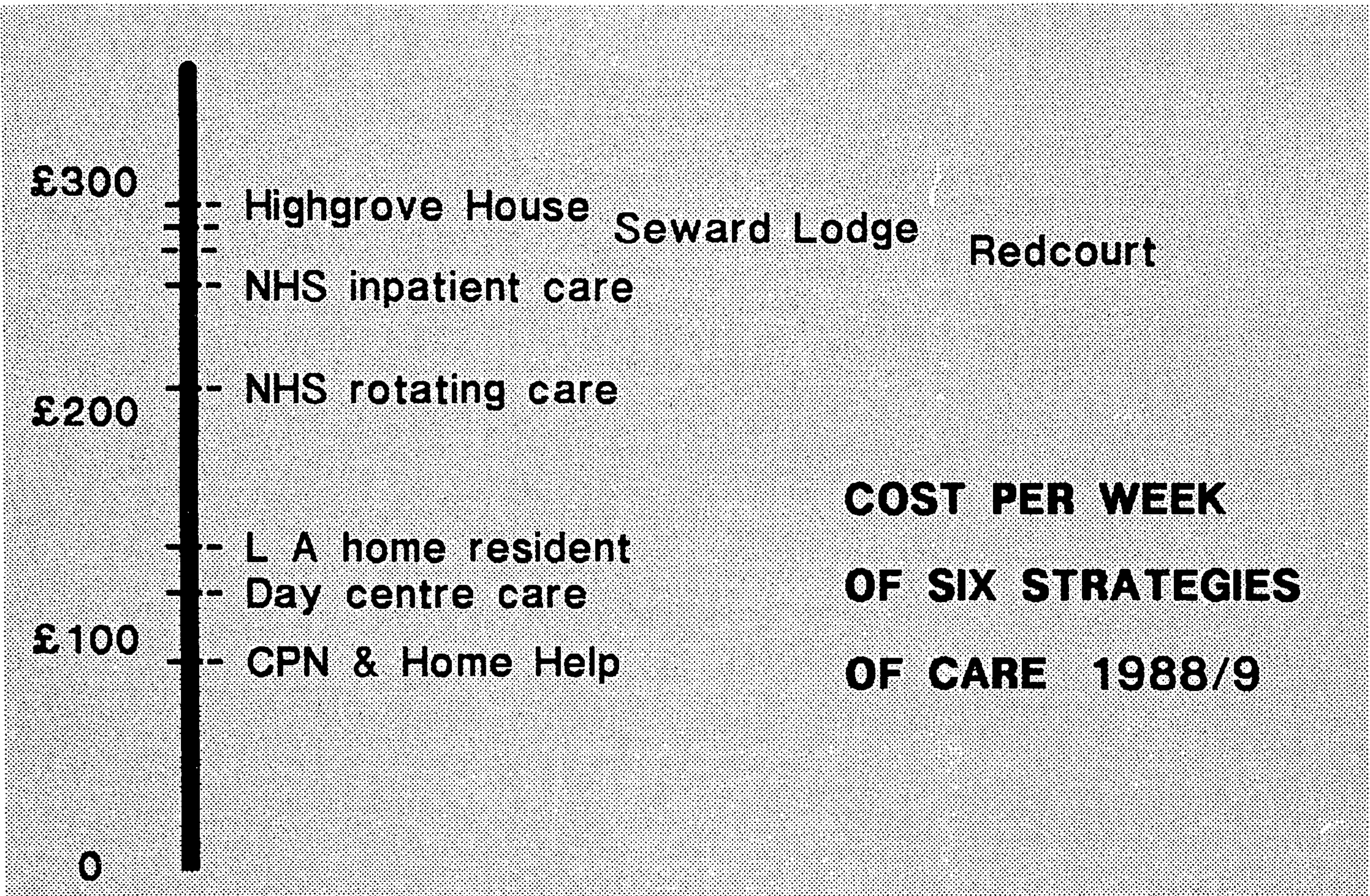



Figure 3.1

## CHAPTER 4: THE NEED FOR SERVICES

Care of the elderly has traditionally been a Cinderella branch of health and welfare services (Beaumont and Sixsmith, 1984). This is particularly the case with the elderly mentally ill. Many districts in Britain have had little or nothing in the way of specialist services for this client group, despite increasing numbers of very dependent people. Moreover, the services that were available were usually provided in long-stay psychiatric hospitals with the accompanying problems of stigma and institutionalisation. Thus, an evaluation of need for a new service has to examine a range of issues: the prevalence of a particular illness or disability within the community; the current level of provision; and the kinds of service that are required.

In this section, two issues are addressed. Firstly, what is the level of need for services in the districts in which the experimental homes are situated and how far do existing services match this need? Secondly, to what extent were the three homes a response to particular local circumstances and requirements?

### THE LEVEL OF NEED

As already mentioned, the term "Rising Tide" was coined to describe the increase in the numbers of older people suffering from senile dementia. The increased demand on caring services would also be compounded by the gradual uncovering of an "iceberg" of people suffering from dementia who were unknown to the health or social services; living on their own, or being cared-for by unsupported relatives and friends.

But is this assumption justified? How far below the surface does the "iceberg" extend; what is the actual difference between revealed and actual need? Do current levels of service provision for this client group match local needs or is there indeed an "iceberg" of unmet needs?

The starting-point is to estimate levels of dementia within the community. Although a lot has been written on the epidemiology of dementia, it is nevertheless difficult to draw firm conclusions about the number of cases which one might expect at any one time. The seminal study, in Newcastle in the 1960s, suggested that about six per cent of all over-65s would be suffering from dementia. This would mean, for example, that an average health district with a population of about a quarter of a million would contain some 2,250 sufferers. In the early 1970s, it was thought that up to 20% of the over 75s might have some form of dementia. More recent work has suggested that this is a considerable over-estimate. Bergmann and associates (1979) estimated a prevalence of just below 3% of all over-65s, which was the same as the estimate by Gurland and associates (1983). Further analysis of the Gurland database and a review of a number of studies by Ineichen (1987) leads to a more refined prevalence estimate of 1% of persons aged 65-74, and 10% of persons aged 75 and over. It should be pointed out that some of the studies were not entirely representative in terms of the population sample, in which case bias is probably downwards. Research undertaken by the Department of Psychiatry, University of Liverpool, of a random sample of people aged over 65 shows a prevalence of 4.3% (Copeland et al, 1987).

At a local level, using the recent prevalence estimates by Ineichen (op cit) as the basis of calculation, a health district of average age distribution would contain about 1,500 persons with dementia, and numbers will increase

to reach 1,725 cases by the year 2001. In those health districts with the very oldest populations, such as Worthing and Torbay, the increase will be more than double.

The population distributions for the health authorities in which the three experimental homes are located are given in Table 4.1. On the basis of these figures, it is estimated that East Hertfordshire and Wycombe would have similar levels of dementia at 1613 and 1660 respectively. Liverpool Health Authority, with a much larger total population and a larger proportion of older people would have about 3736 people with dementia.

Table 4.1 Age structure of populations in 1986

| Age | Persons (1000s) | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Wycombe HA | | Liverpool HA | | E. Herts HA | | England & Wales | |
| 0-64 | 232.0 | 85.3% | 414.0 | 84.2% | 251.4 | 87.4% | 42,289.3 | 84.7% |
| 65-74 | 26.0 | 9.5% | 44.6 | 9.1% | 22.3 | 7.8% | 4,395.9 | 8.8% |
| 75+ | 14.0 | 5.1% | 32.9 | 6.7% | 13.9 | 4.8% | 3,237.8 | 6.4% |
| Total | 272.0 | | 491.5 | | 287.6 | | 49,923.0 | |

Have local services been developed in line with the levels of dementia within the community? The need for any new service can be assessed by looking at the shortfall between estimated need (ie. numbers of people with dementia) and current provision. An exercise was carried out in Wycombe which involved the comparison of estimated numbers of people with

dementia with the number who were actually known to the local Health Authority and Social Services Department. It was not possible to replicate this study in the two other health authorities due to very large research effort required to gain access to and collate the necessary data.

Simply adding up the available services in a district does not give an accurate picture of persons supported. This is for two reasons. Firstly, some services are designed to maintain more persons than they have places, by rotating residents or attendees. Secondly, many persons with dementia consume a bundle of different services. To obtain a reasonably accurate estimate of service consumers, a list of names was compiled from registers of all the statutory agencies that were specifically concerned with the elderly mentally ill both in institutional settings and in the community. These included: the Department of Mental Health of the Elderly; Part III homes with specialist EMI wings; the community psychiatric nursing service; the specialist home help service; local authority day centres. An assessment of numbers of people with dementia within non-specialist Part III homes was facilitated by a recent in-house dependency survey undertaken by Buckinghamshire Social Services. Once assembled, the list of names was examined and multiple entries were eliminated to provide a final list of known dementia sufferers in Wycombe. A total of 883 persons were identified as suffering from dementia and known to the statutory care system.

So how does this figure for known cases compare with the estimated prevalence in Wycombe? Figure 4.1 is an "iceberg" diagram showing that 53% was above the "waterline" and known to the services, while the remaining 47% was below the waterline and unknown. Obviously, this is a crude attempt to assess the extent of level of unmet need in Wycombe. However, the result is clear: a very high proportion of people with dementia are not receiving any specialist service. It could be assumed that there is a similar situation in Liverpool and East Hertfordshire.

Some researchers (Qureshi and Walker, 1989) have suggested that the people who have the most pressing need are in receipt of care. It should also be remembered that the figure for service consumers in the iceberg diagram does not include the voluntary and private provision sectors, which may account for a considerable proportion of the unknown group. There will be a further number of people who are supported by relatives and neighbours within the informal sector, without recourse to formal services.

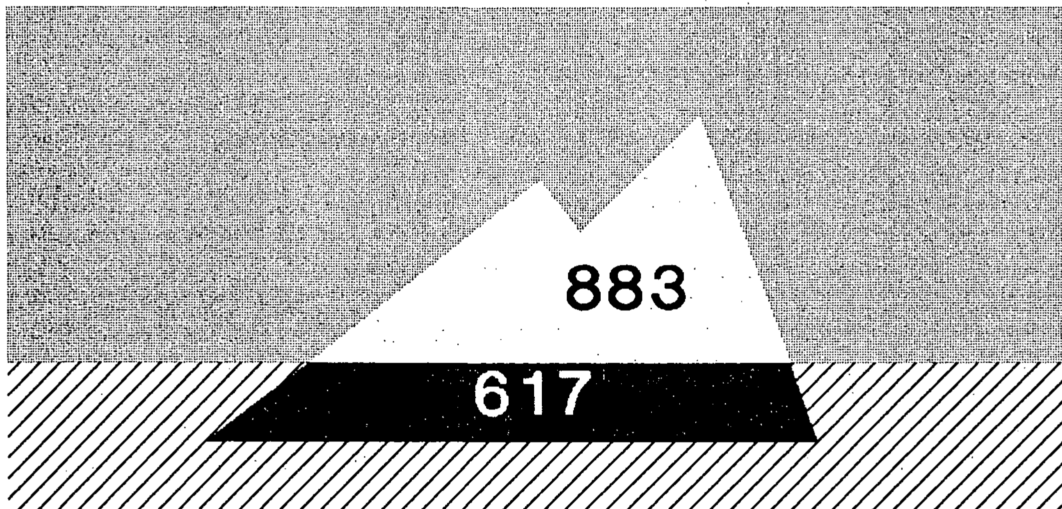
However, it must remain a worrying fact that many mentally ill older people are not getting appropriate care. A recent survey of a range of long-stay accommodation for elderly people has shown high levels of cognitive impairment in all types of setting (Harrison et al, 1990). A study of dependency within Part III homes in Buckinghamshire was undertaken as part of the present study. Again this points to a relatively high level of disability even in those homes which do not specifically cater for the elderly mentally ill (Crosby, 1986). Are these people really getting the kind of service they require? Moreover, current research being undertaken by the Institute of Human Ageing in Liverpool (Sixsmith, 1990) suggests that there are a whole range of factors determining who gets what service; the availability of information, the ability to negotiate the benefit system, the geographical proximity of facilities and inter-agency lines of communication all act as a randomising mechanism for rationing care.

## RESPONDING TO LOCAL NEEDS

The question of meeting local need is not just a matter of "how much?", but also "what kind?". Sixsmith (1988) suggests that some agencies have responded insensitively to the complex needs of local communities. To an extent this is understandable given the pressing requirement to develop new services in line with the Rising Tide of demand. However, attention must be given to local circumstances and requirements if appropriate care is to be provided.

In evaluating a new service one must ask a range of questions: does it complement existing services; does it fill a clear gap in the market; does it provide consumers with more choice? At this point it is important to look at the local contexts in which the three experimental units emerged.

Highgrove House: Services for the elderly mentally ill in the Wycombe area were provided by both the Health Authority and the Social Services Department. Within the NHS, people requiring long-stay accommodation were serviced primarily outside the District by a large psychiatric hospital near Aylesbury. It should be pointed out that this hospital was to be closed after the period of the research and long-stay psychogeriatric services were to be transferred to local NHS units. The Department of Mental Health of the Elderly provided short-term beds and day care. Buckinghamshire Social Services provided specialist residential care in EMI wings in two Part III




**AN ICEBERG DIAGRAM SHOWING THE NUMBER OF PERSONS WITH DEMENTIA KNOWN TO THE CARE SYSTEM (883) AND NOT KNOWN, OR KNOWN TO VOLUNTARY SERVICES (617)**

Figure 4.1

homes. However, it already been noted that the non-specialist Part III homes serviced a very dependent group of people. When Highgrove was originally proposed, the perceived niche in the service market was for people who presented problems that could not be easily managed in Part III settings. Normally, these people would have been admitted to a long-stay ward in the psychiatric hospital. As a social services residential home, Highgrove was set up to provide an alternative to hospital care, with an emphasis on providing a "normalising" and domestic environment.

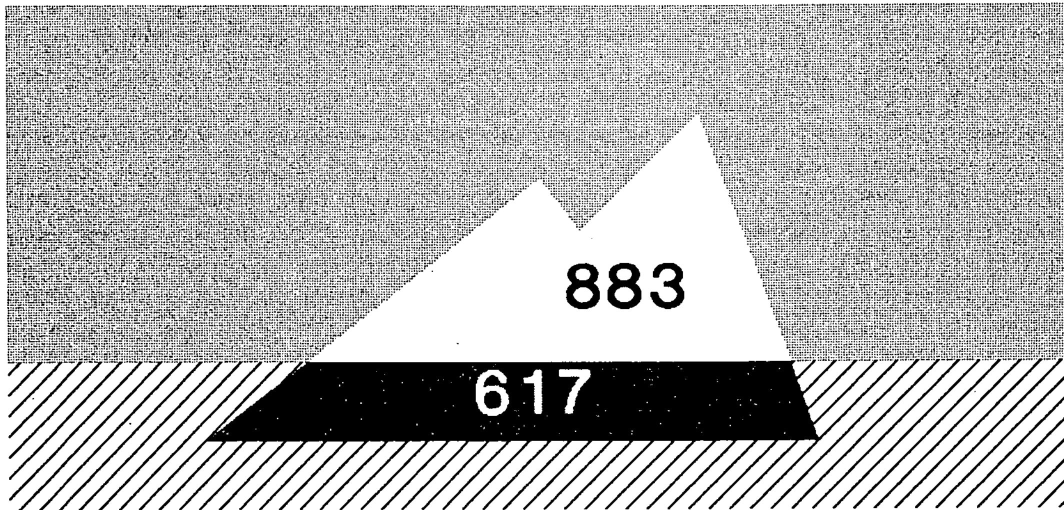
Redcourt: The development of Redcourt should be seen in the context of the wider process of the "de-institutionalisation" of continuing care for the mentally ill and the closure of long-stay psychiatric hospitals. The original residents were all taken from a single ward in Rainhill Hospital on Merseyside. The prime objective of Redcourt was to provide the care these people required in a setting that was both homely and humane. The local Health Authority provides a range of psychogeriatric services at hospital sites, including assessment facilities, acute care, respite care and day care. Liverpool has also developed a specialist domiciliary service to support elderly mentally ill people in their own homes. Redcourt was intended to provide accommodation for very dependent people who required permanent nursing care. It is also noted that when Redcourt opened in 1986, there were only three registered private nursing homes in Liverpool. This meant that many older people were being admitted to homes a considerable distance from their own locality. In Particular, the Wirral and Southport areas have catered for the Liverpool market. Redcourt was thus one of the first developments to fill the service vacuum in the city. Rapid growth in the private sector has occurred in Liverpool in recent years. However, only two of the fifty nursing homes are registered for EMI clients.

Seward Lodge: The development of Seward Lodge took place in an almost complete service vacuum. East Hertfordshire had no specialist services for the elderly mentally ill. During the period of the research there was no psychogeriatrician in the health authority, although one has since been appointed. Any client requiring psychogeriatric care had to be serviced in neighbouring health authorities. Seward Lodge was the first step in providing a locally-based service for elderly people with dementia. In this context, Seward Lodge was set up to provide a comprehensive range of provision to meet diverse local needs, including day care, relief residential care and long-stay residential care. It was also envisaged that care could be coordinated within a single unit to meet the needs of individuals as they progressed through the course of their disability. The least dependent could continue to live in their own homes and attend the day centre. As they became more dependent, they could progress to a combination of day care and relief admissions. Finally, the most dependent could be admitted as a permanent resident.

## CONCLUSION

The development of the three experimental units should be seen in the context of increasing demand, a relative absence of specialist services and a shift away from institutionalised, hospital-based care. It can also be seen that specific local circumstances gave rise to very different units, reflecting need within existing patterns of provision. With Seward Lodge, the absence of local provision prompted the development of a comprehensive service within a single unit. In the case of Highgrove, a much more specialised role

was adopted to complement the range of existing services and extend consumer choice. In the context of Liverpool Health Authority, the need was for non-institutional long-stay care as well as existing hospital-based acute care and day care.




AN ICEBERG DIAGRAM SHOWING THE NUMBER OF PERSONS WITH DEMENTIA KNOWN TO THE CARE SYSTEM (883) AND NOT KNOWN, OR KNOWN TO VOLUNTARY SERVICES (617)

Figure 4.1

## CHAPTER 5: STAFF ACTIVITY STUDY

The three experimental homes have different backgrounds in a number of respects. Highgrove House is operated by Social Services, with care staff employed by the Local Authority, but with a team of supporting workers from a number of disciplines, most of whom are employed by the Health Authority. Redcourt is operated by the Health Authority, and run more or less as if it were a small separate hospital, except that the nurse in charge is not fully independent and must refer some decisions to a senior nurse in the hospital a quarter of a mile away. Seward Lodge is also run by a Health Authority, but the nurse in charge operates much as a Social Services officer in charge. However, at Seward Lodge most of the staff are unqualified general assistants, combining a caring and domestic role.

The capital and labour resource endowments were therefore different, but the consumption of resources such as food, drugs and other consumables was not subject to any limits, nor was it significantly different between the units, all of which followed a minimal medication policy, produced food and drink ad lib, and bought clothes and gift items for the clients as they were required, or seemed potentially beneficial. In most cases the clients had their own funds which were adequate for these purposes; if not unit funds were used.

A self-contained study of the capital of each home, that is the buildings, was undertaken in order to examine their suitability, and to draw conclusions about their contribution to quality of care, or at least their conformity to existing theories concerning the best type of accommodation for the elderly mentally ill. This study is included in the later section on the Physical Environment.

It was therefore necessary to study staffing in the homes, and in order to do this it was decided to undertake an activity analysis study for a complete week in each home, in order to find out what tasks were performed, by whom, and with which clients. This information could then be interpreted in the light of each home's objectives, and it could also be used to see how evenly, or unevenly, the care was distributed among all the clients, and whether any particular type of client laid an especially heavy burden upon staff.

In order to provide a comparison from outside the experimental setting, we decided to undertake a similar study in a modern but conventional hospital continuing care psychogeriatric ward. Key data about the homes, against the background of which the findings of the studies can be examined, are given in Tables 5.1 and 5.2. Staffing data is given in Table 5.1, and some dependency information on the clients in Table 5.2.

### STAFFING LEVELS

Table 5.1 gives certain key statistics for the four units. Highgrove had the highest staff/client ratio - since Seward Lodge took 13 day attenders it appeared worse off than Redcourt. If a day attender is counted as half a resident, then Seward Lodge would be as well staffed as Highgrove. It is not, however, possible to index a day attender to a resident particularly meaningfully, since the type of care is different.

**Table 5.1 Staffing data (at time of Activity Analysis Study)**

| Home | Clients | Qualified Staff(wte) | Unqualified Staff(wte) | Q/C | UQ/C | S/C |
|---|---|---|---|---|---|---|
| Highgrove | 21 | 9 | 18 | 0.43 | 0.86 | 1.29 |
| Redcourt | 22 | 11.25 | 14 | 0.51 | 0.64 | 1.15 |
| Seward Lodge | 20 res | 7 | 18 | 0.35 | 0.9 | 1.25 |
| | 13 day | 3 | 5.25 | 0.23 | 0.4 | 0.63 |
| CC ward | 23 | 9 | 8.5 | 0.39 | 0.37 | 0.76 |

The comparison unit was the worst off, not only in staff per client, but also in observed records per staff. This is because absenteeism was higher during the study period than in the other units.

The qualified/unqualified ratios were very different between the three Health Authority units and the Social Services unit. In fact, Seward Lodge has subsequently reduced the number of qualified staff, partly in response to the recent regrading exercise for nursing staff.

Seward Lodge is different from the other units in that it has adopted completely the generic worker model. Its staff carry out almost all the domestic work as well as caring for the residents. This distorts the comparison with the other units, where the domestic work is under the control of the domestic supervisor, and carried out by her staff, and where different proportions of cooking are carried out on site. Redcourt employed about 10.5 whole-time equivalent (wte) domestic, catering, estates and portering staff. Highgrove employed 4 wte. We have no such breakdown for the comparison unit. Redcourt is on three floors (two for the residents) and is larger than Highgrove, but the enormous difference between 10.5 and 4 staff remains unexplained.

To summarise the staffing differences, Highgrove was best endowed, closely followed by Seward Lodge, then Redcourt, with the Ward trailing with only three fifths of Highgrove's staff. It was in the area of unqualified staff that the disparity was most marked. Redcourt had the highest ratio of qualified staff (qualified here means with either a social services qualification or a nursing qualification) with Highgrove and the Ward close together and with Seward Lodge last.

## DEPENDENCY LEVELS

Table 5.2 summarises dependency levels within the three units and a comparison psychogeriatric ward. The CAPE procedures grades people from A, (independent, comparable to people living without support in the community) to E (maximum dependency, severe cognitive impairment and behavioural defecits). The Chrichton Royal scores for residents are grouped here according to high medium and low dependency. Dependency, whether measured by CAPE or Chrichton Royal was highest in the Ward, second

highest in Redcourt, then Seward Lodge, and lowest at Highgrove. However, this difference did not appear so marked to research staff who knew each home, and it is possible that dependencies at Highgrove were relatively underreported. Both Redcourt and the Ward had about a quarter of residents who were totally immobile. Each of these facilities had originally gained some of their residents from a decanting exercise from a large mental illness hospital, and this accounted for the highly dependent states of some clients.

**Table 5.2 Client dependency data**

| Home | % of clients: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | CAPE (Survey) | | | | | IMMOBILE | CRICHTON ROYAL | | |
| | A | B | C | D | E | | HIGH DEP | MED DEP | LOW DEP |
| Highgrove | 6 | 6 | 32 | 50 | 6 | 0 | 0 | 55 | 45 |
| Redcourt | na | | | | | 27 | 32 | 63 | 5 |
| Seward Lodge | 0 | 0 | 8 | 20 | 72 | 5 | 5 | 69 | 21 |
| CC Ward | 0 | 5 | 5 | 10 | 80 | 23 | 45 | 40 | 15 |

**THE STUDY**

The two available methods for collecting systematic data on staff activities were observation by the survey team, and self-reporting. Observation is more objective, but suffers from the theoretical drawback that the observers might not thoroughly understand, and might accordingly misinterpret, the activities performed. The most important difference between the two methods is the relative information productivity of the two systems; self reporting yields about four to six times as much information per member of research-staff involved.

We therefore decided to undertake the main study by means of self-reporting, and to perform some smaller observational studies in order to test for consistency. Each member of care staff, including members of supporting disciplines such as occupational therapy or social work, was given a diary in which the week was divided into quarter hour slots. She was asked to describe each quarter hour period in the following terms:

Was it mainly

direct, face to face care (eg bathing, conversation)

or direct, not face to face (eg making a cup of tea)

or indirect (eg discussion, handover)

or all other activities ?

Who were the residents involved ?

Who, if any, of the residents were being very demanding ?

A brief description of the activity.

After a pilot study at Highgrove House, the form of the data collection sheet was changed. We wanted to investigate the degree to which the generous staffing levels of the experimental homes were allowing them to deliver the special care which they all claimed - care, that is, over and above the routine health and comfort care which is the first aim of psychogeriatric residential homes. This is the sort of care which is probably the most difficult for even a loving relative to give - care designed to stimulate the minds and to engage the interests of the clients. Interactions were therefore classified as Demanding, Routine or Positive. This last category was designed to capture the special care described above.

We also found that the 'Direct/Indirect' distinction did not work very well, and we changed this to 'With/Not with' clients. The episodes were then classified as 'With','Task','Administration' and 'Break', with an 'Observation' category for night duty. Small notebooks were given out since the diary folders were too large to be carried around, and were filled in during breaks, or quiet periods.

In the case of the comparison ward, since it was part of a hospital, some of the care was given off-ward by occupational therapists or occupational therapy aides. We have included these encounters in the study for all the analyses except those which look at the different activities of different ward-specific staff.

## STAFF DATA

The total number of observations for the three units are given in Table 5.3.

**Table 5.3 The total number of observations for the three units**

| | |
|---|---|
| Highgrove | 3795 |
| Redcourt | 3337 |
| Seward Lodge | |
| day | 941 |
| residential | 3009 |
| Ward | 2288 |

These were divided as given in Table 5.4 below between with clients and not with clients: (percentages in brackets)

| | With % | Not with % |
|---|---|---|
| Highgrove | 2010 (53) | 1785 (47) |
| Redcourt | 2123 (64) | 1214 (36) |
| Seward Lodge | | |
| day | 533 (57) | 408 (43) |
| Residential | 1687 (56) | 1322 (44) |
| Ward | 1399 (61) | 889 (39) |

**Table 5.4 Observations "with" and "not with" clients**

Taking Senior, Junior, Night and Other staff separately, the percentage of total staff time accounted for by periods with clients is given in Table 5.5:

| | Senior | Junior | Night | Other |
|---|---|---|---|---|
| Highgrove | 38 | 71 | - | 40 |
| Redcourt | 62 | 71 | 55 | 85 |
| Seward Lodge | 49 | 59 | 56 | - |
| Ward | 59 | 63 | 61 | - |

**Table 5.5 Percentage time with clients**

Highgrove's senior staff spend least time with residents. Redcourt has the highest proportions of staff with clients for all except night staff. The differences between the ratios for night staff were not significant at the 5% level, nor were the differences between the ratios for junior staff at Highgrove, Seward Lodge and the Ward.

There is a very large difference between the ratios for Other staff at Highgrove and Redcourt. This category comprises different types of staff at the two homes. At Highgrove it comprises the multi-disciplinary team, including Occupational Therapist, Doctor, Community Psychiatric Nurse and other specialists on a sessional basis. At Redcourt it covers only Activity Organisers, who are untrained staff performing a diversional therapy role.

We divided not-with-clients records into four categories, Administration, Task, Break and Observation at night. The main category of staff activity not undertaken with clients is the classification "Task".

Tasks can be subdivided into housekeeping and professional/clerical, such as report writing. Within these subdivisions we formed further categories; within professional/clerical we have Supervision, Handover, Report writing, Other writing, Discussions and Meetings. Within housekeeping we have Tidying, Washing/laundry, Cleaning, Ironing, and General domestic. There is also a residual category for such items as "collecting prescription and buying a necklace for resident".

Table 5.6 gives a breakdown of records into these categories. Administration has been sub-totalled with Professional Clerical because of their similarity. Column percentages are given in brackets.

| | Highgrove | Redcourt | Seward L | Ward |
|---|---|---|---|---|
| TOTAL NOT-WITH-CLIENTS | | 1785 | 1214 | 1730 889 |
| <u>Administration</u> | 195 | 128 | 208 | 112 |
| <u>Tasks</u> | | | | |
| <u>(a)Professional/Clerical</u> | | | | |
| Supervision | 67 | 14 | 0 | |
| 3 Handover | 252 | 140 | 130 | 224 Report |
| Report writing | 214 | 188 | 25 | 3 |
| Other writing | 56 | 19 | 33 | 3 |
| Discussion | 192 | 36 | 7 | 66 |
| Meeting | 105 | 19 | 70 | 17 |
| <u>Sub-total</u> | 1081 (61) | 544 (45) | 473 (27) | 428(48) |
| <u>(b)Housekeeping Tidying</u> | | | | |
| Tidying | 53 | 9 | 11 | 23 |
| Washing/laundry | 74 | 14 | 237 | 28 |
| Cleaning | 17 | 8 | 90 | 12 |
| Ironing | 0 | 0 | 26 | 0 |
| General Domestic | 2 | 0 | 68 | 0 |
| <u>Sub-total</u> | 146 (8) | 31 (3) | 432 (25) | 63(7) |
| <u>(c)Residual</u> | 320 (18) | 220 (18) | 404 (23) | 269(30) |
| <u>Break</u> | 238 (13) | 274 (23) | 363 (21) | 109(12) |
| <u>Observation</u> | 0 (0) | 145 (12) | 58 (3) | 20(2) |

**Table 5.6 Different categories of record**

It is immediately apparent that Highgrove stands on its own, with a heavy professional/clerical load, equivalent to about eight full person days. Seward Lodge has far more Housekeeping than the others. This is because the staff at Seward Lodge also perform the jobs done in the other homes by domestic staff. Other noteworthy points are the low domestic loads at Redcourt and the Ward, and the low overall figure at the Ward. Records 'with client' were divided into Positive, Demanding and Routine, as explained above. We first compared the total number of Positives per client (Table 5.7).

| Positive whole-equivalent records per client | |
|---|---|
| Highgrove | 13.5 (3.4 hours) |
| Redcourt | 10.9 (2.7 hours) |
| Seward Lodge | 15.3 (3.8 hours) |
| Ward | 9.0 (2.2 hours) |

**Table 5.7 Positive records**

A considerable disparity is noted, with Seward Lodge, then Highgrove, giving more Positive care than the others. The same exercise was carried out for Demanding care (Table 5.8).

| **Demanding whole-equivalent records per client** | |
|---|---|
| Highgrove | 12.1 (3.0 hours) |
| Redcourt | 11.5 (2.9 hours) |
| Seward Lodge | 5.5 (1.4 hours) |
| Ward | 8.3 (2.1 hours) |

**Table 5.8 Demanding records**

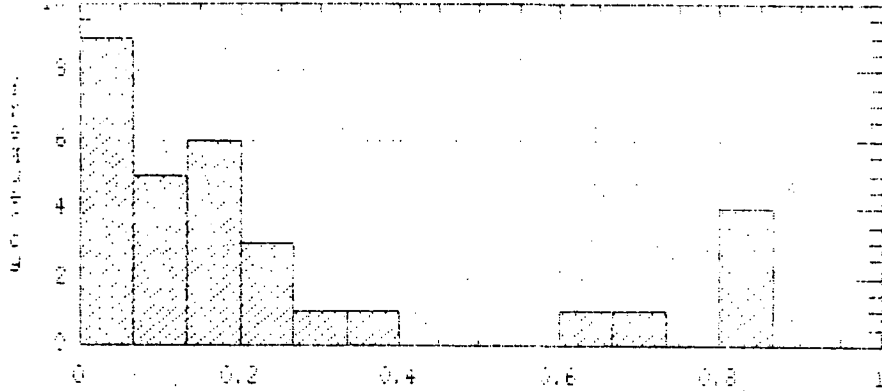
Highgrove has more of this type of care than the others. In this case, Seward Lodge and the Ward had relatively little. Table 5.9 gives data for Routine Care (This is not the residual from the total staff input over the study period, since the record types 'Task' and 'Break'were excluded; only 'With client' records were used in this part of the analysis).

| **Routine whole-equivalent records per client** | |
|---|---|
| Highgrove | 70.0 (17.5 hours) |
| Redcourt | 74.0 (18.5 hours) |
| Seward Lodge | 46.1 (11.5 hours) |
| Ward | 43.5 (10.9 hours) |

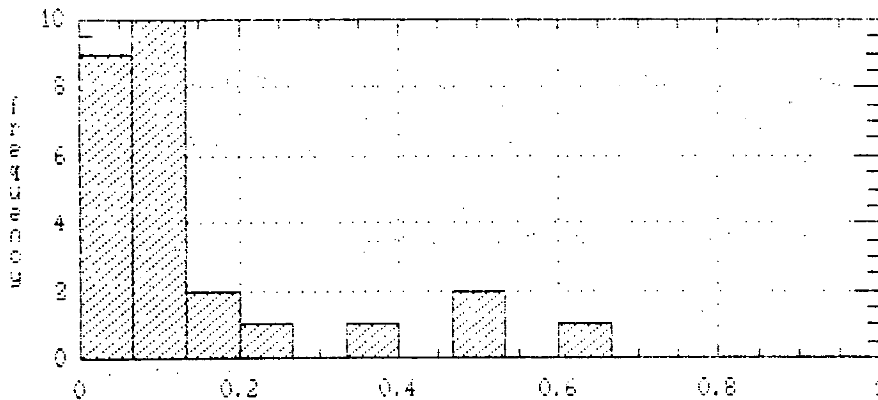
**Table 5.9 Routine records**

Redcourt gives most Routine care, followed by Highgrove, then the Ward and Seward Lodge. In the case of Seward Lodge, it should be remembered, two fifths of clients were only present for day care.

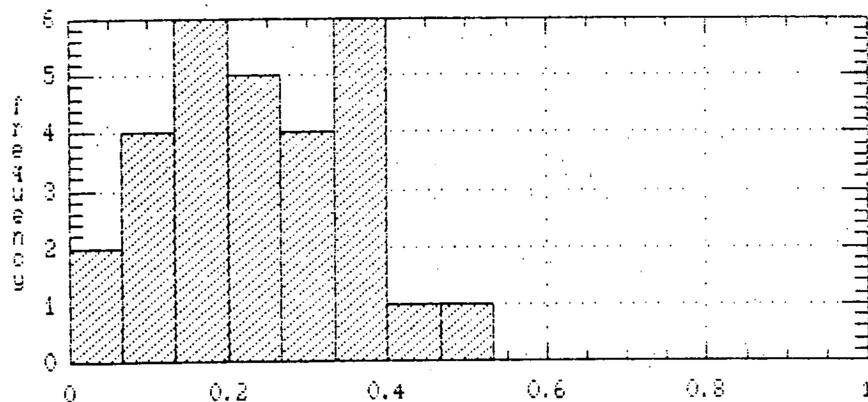
The distribution of Positive and Demanding episodes over staff at each site, in relation to staff giving direct care, is shown on Figures 5.1 and 5.2. The




POSITIVES/TOTAL 'WITH': ALL STAFF
REDCOURT




POSITIVES/TOTAL 'WITH': ALL STAFF
SEWARD LODGE




POSITIVES/TOTAL 'WITH': ALL STAFF
COMPARISON WARD

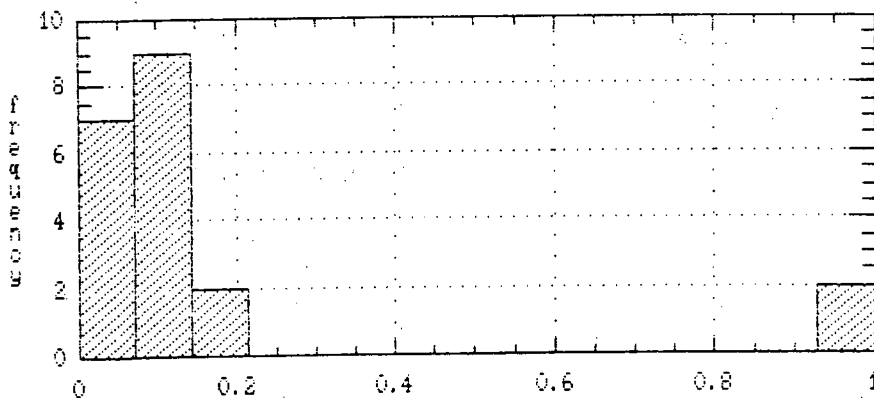



Figure 5.1

**THE DISTRIBUTION OF POSITIVE CARE AS A PROPORTION OF ALL FACE TO FACE CARE AT ONE OBSERVATION**

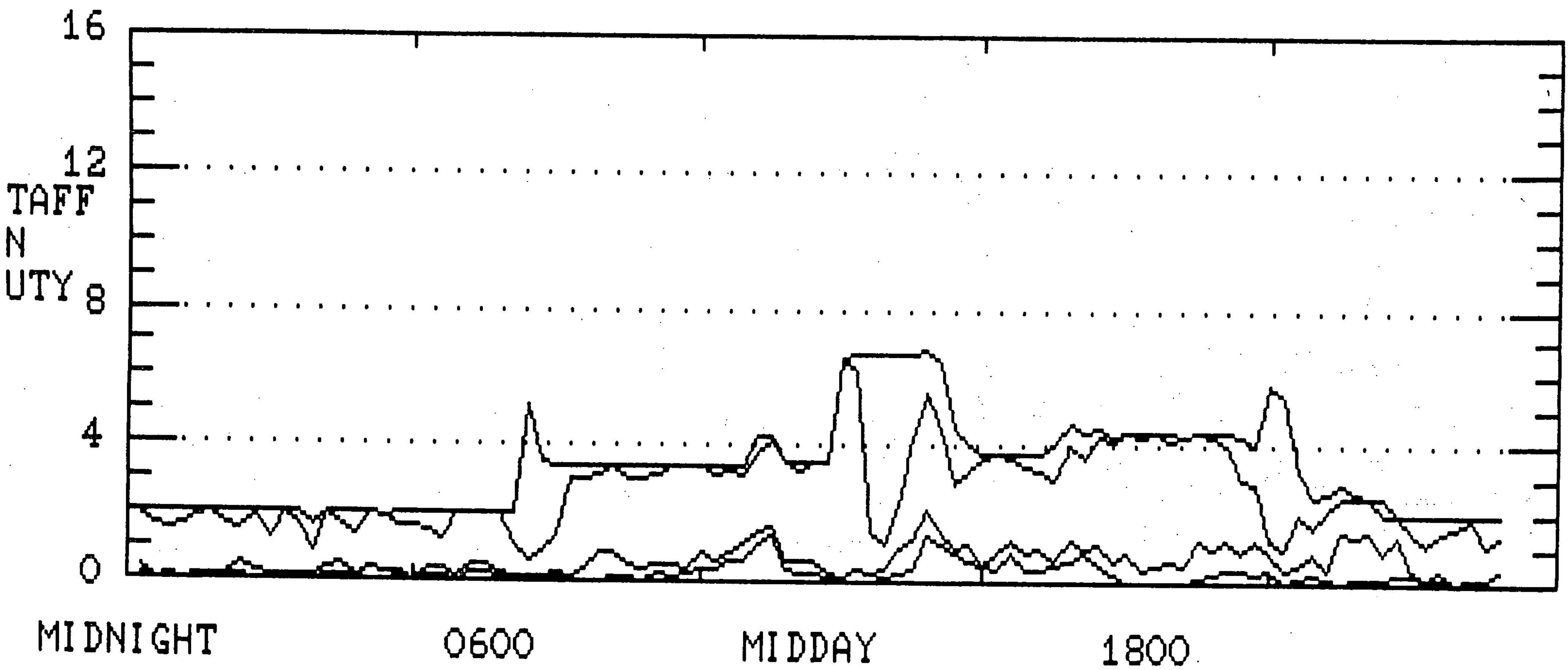



Figure 5.7 **COMPARISON WARI**

absence of any underlying relationships. But the mass of failures lead us to believe that the Dependency schedules most commonly used do not give information from which it is possible to infer the proportion of a home's labour resources which will be devoted to different clients.

### The distribution of care

The distribution of total care over different clients is shown in Figures 5.8 and 5.9. The horizontal axis shows the percentage of total with-clients care, and the vertical axis shows the number of clients. Thus, for example, we see in Figure 5.8 (top) that five clients each consumed between four and five percent of total with-clients care.

The Comparison ward and Redcourt distributed their care most evenly, with, in Redcourt, fifteen out of twenty-two clients, and in the ward, sixteen out of twenty-two, consuming between three and five percent of care each. In Highgrove and Seward Lodge the spread was greater, with more clients consuming a little or a lot, with correspondingly fewer consuming the average.

Looking solely at Demanding care, the distributions are approximately bimodal, with a quarter to a fifth of clients consuming under one per cent, a quarter consuming about four percent, and in each case one or two very heavy consumers. Demanding care is shown in Figure 5.10.

In Highgrove and Seward Lodge Positive care never fell below one percent, but in all units the spread was high. Except in Redcourt there were a small number of clients who each received over ten per cent of positive care. In the comparison ward three clients accounted for thirty eight per cent of the Positive care, and in Seward Lodge one client received twenty seven per cent of all Positive care. Positive care is shown in Figure 5.11.

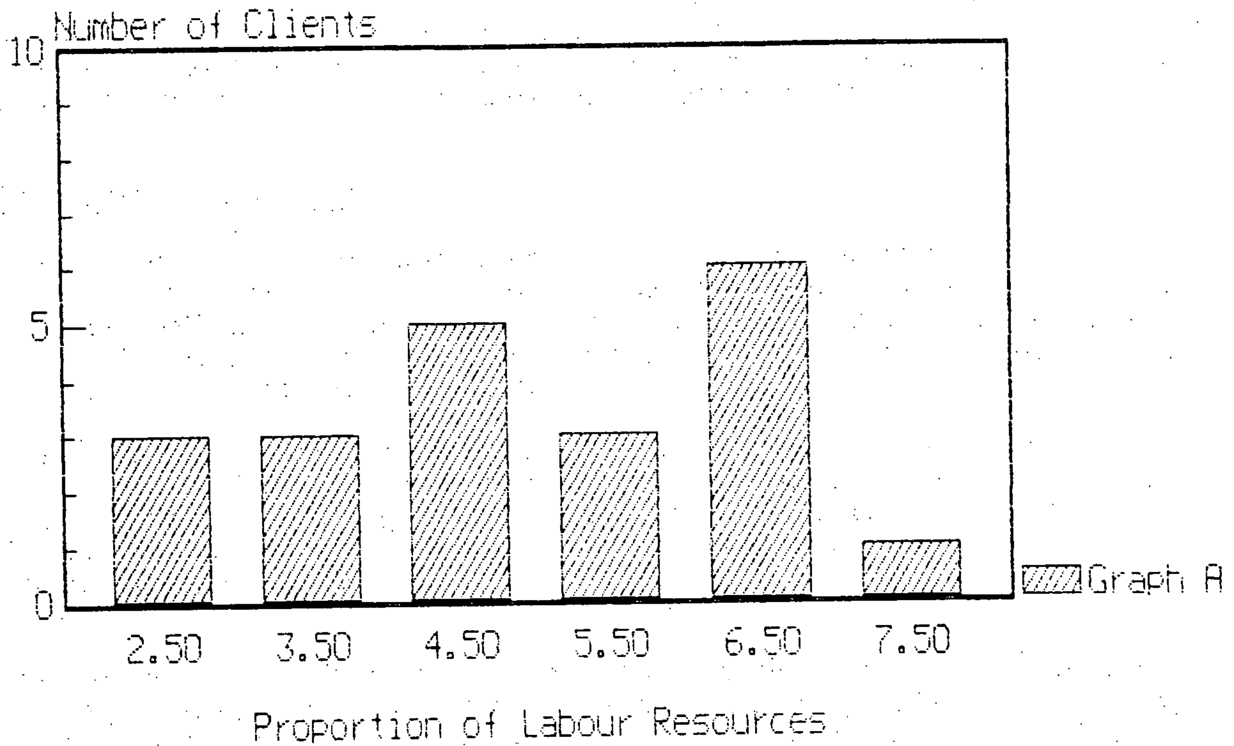
### Are there 'low cost' and 'high cost' clients?

At Redcourt there was no correlation between Positive and Demanding care over clients, but in the other three homes there was a significant positive relationship. Overall, every hour's Demanding care above average predicted twenty minutes Positive care above average. This was not compensated by a reduction in Routine care, which was independently distributed. So there were high cost and low cost clients, both in terms of overall labour resource consumption, and in terms of the two non-routine types of care.

Overall, there were nine clients who each consumed less than three per cent of with-client resources, and six who consumed over seven per cent; assuming that all not-with-client care (forty two per cent of the total) is distributed equally over all clients, this implies that the more 'expensive' clients consumed sixty-five per cent more than the 'cheaper' clients.

## CONCLUSION

What, then, are the main conclusions to draw from all the figures presented in this section? First, and most obviously, care is distributed unevenly between clients. In terms of maximizing some form of social welfare function this may be for the best. But in simple terms, if care were a service for which private payment were made, it would not be seen as 'fair' for the



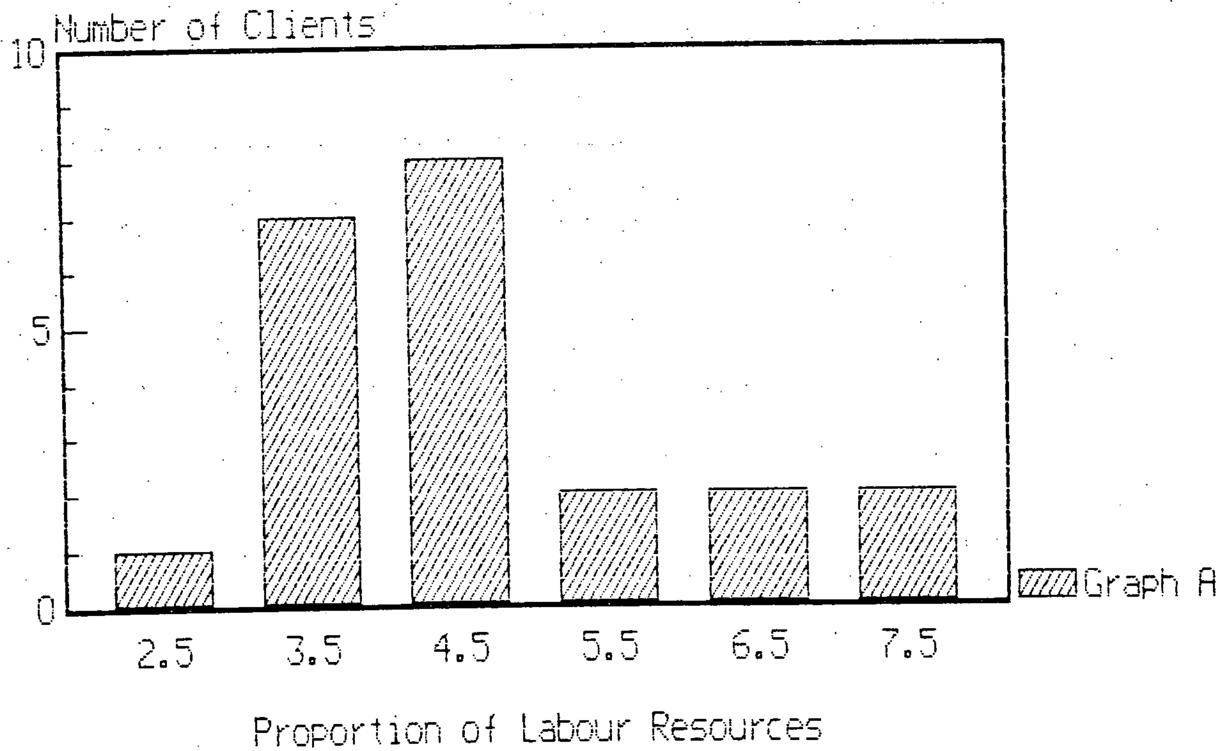
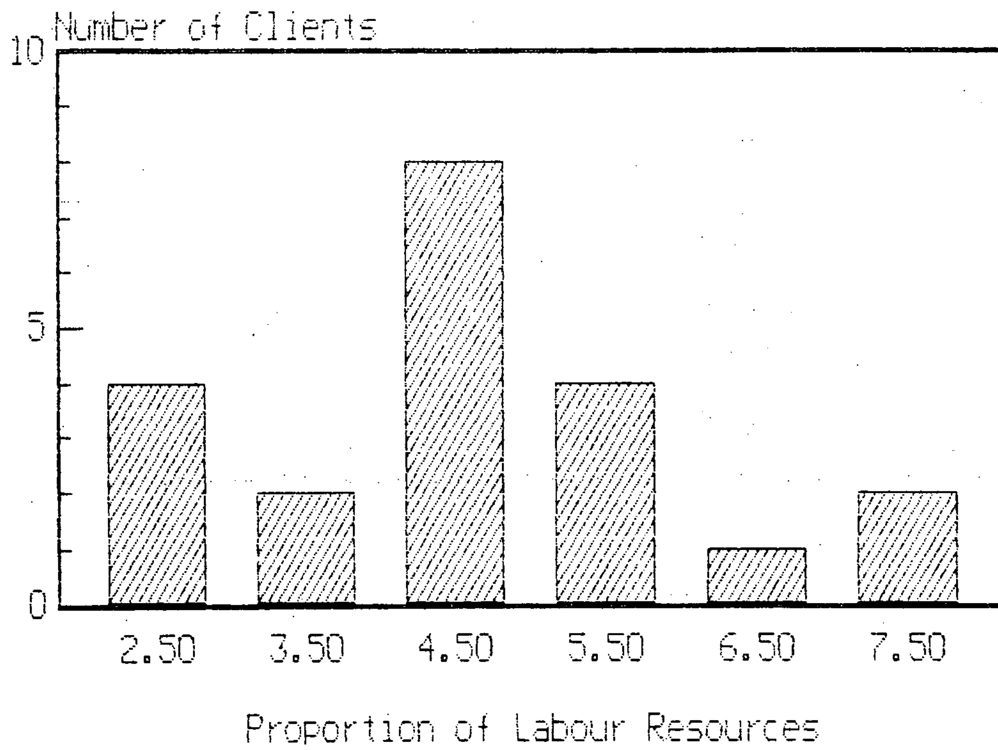




Figure 5.8



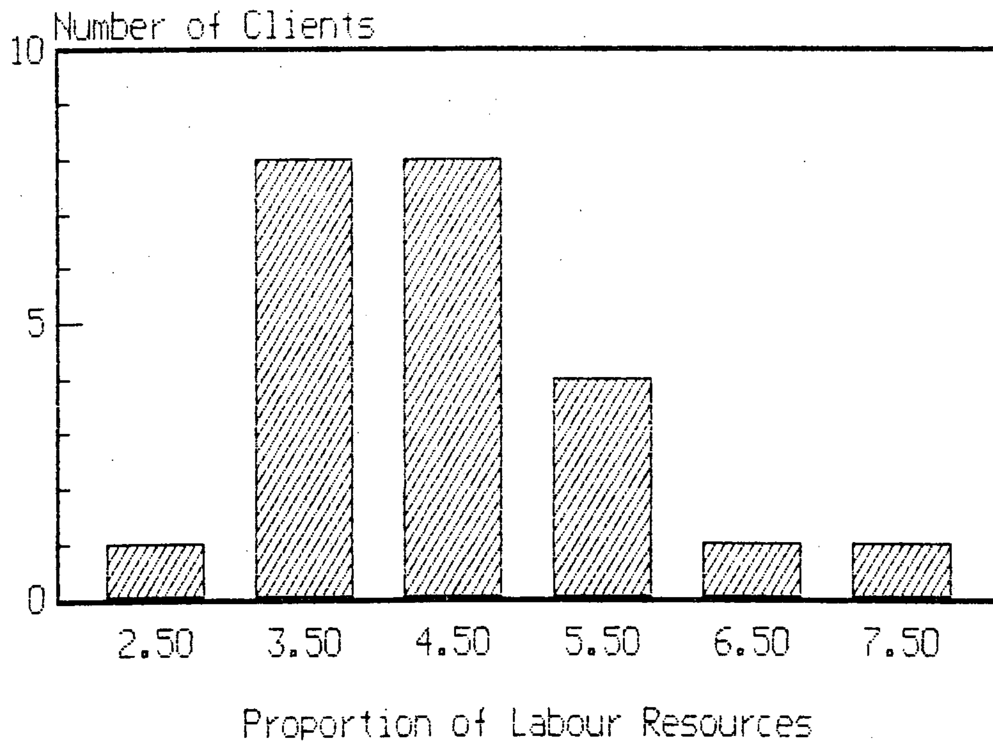
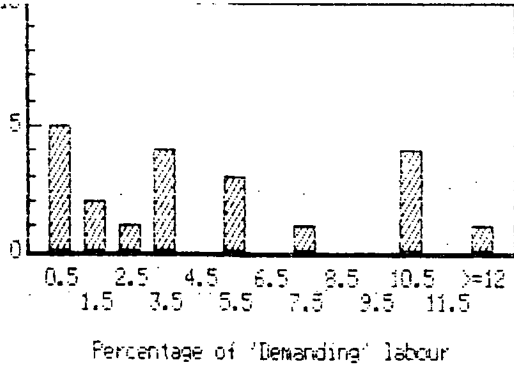
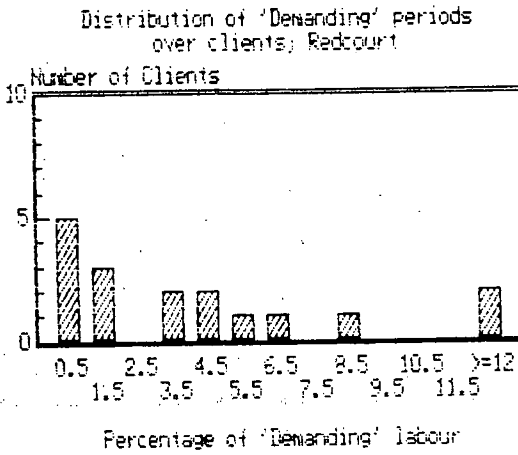
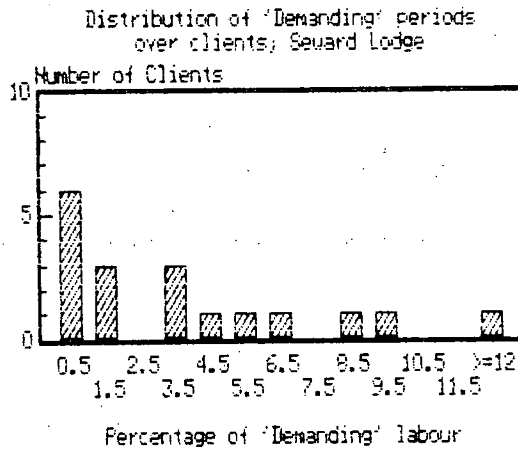




Figure 5.9



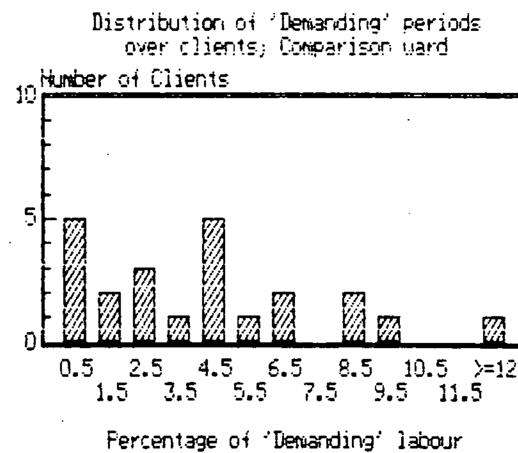
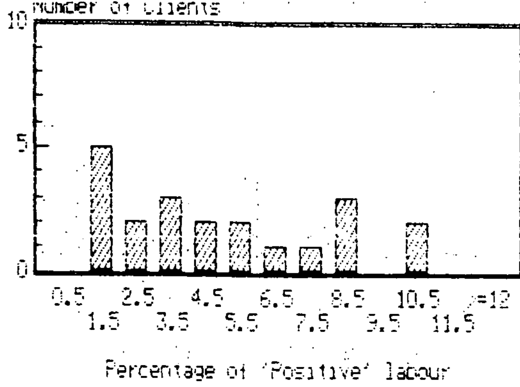
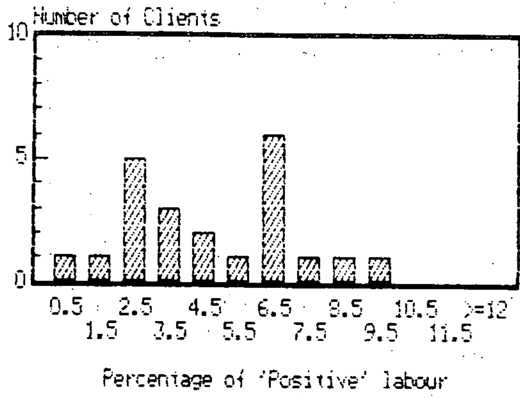



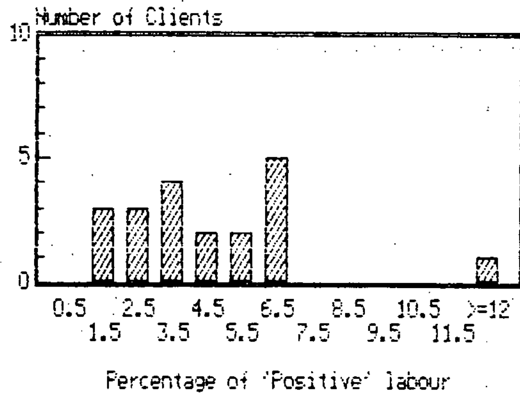

Figure 5.10




Distribution of 'Positive' periods over clients; Redcourt




Distribution of 'Positive' periods over clients; Seward Lodge




Distribution of 'Positive' periods over clients; Comparison ward

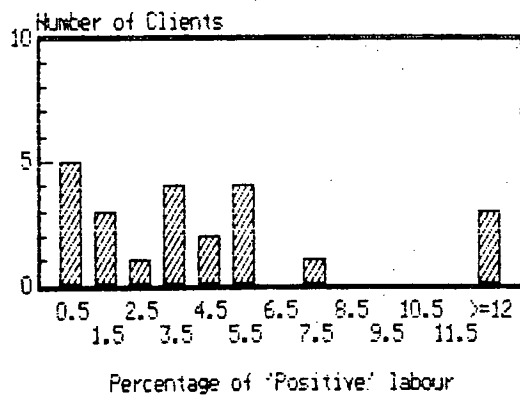
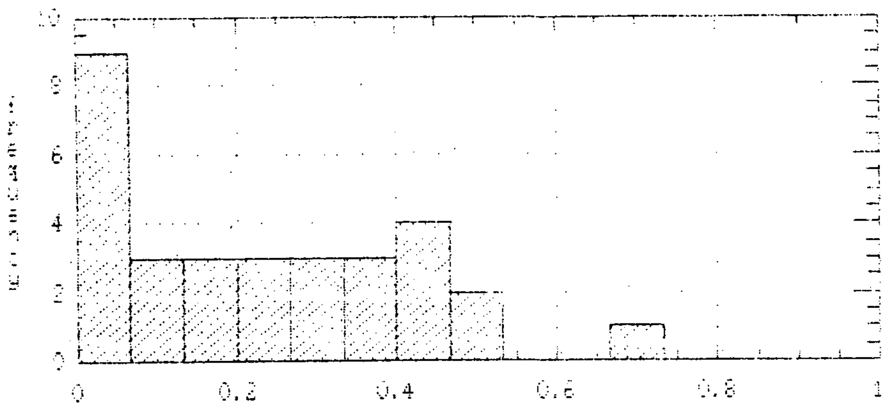
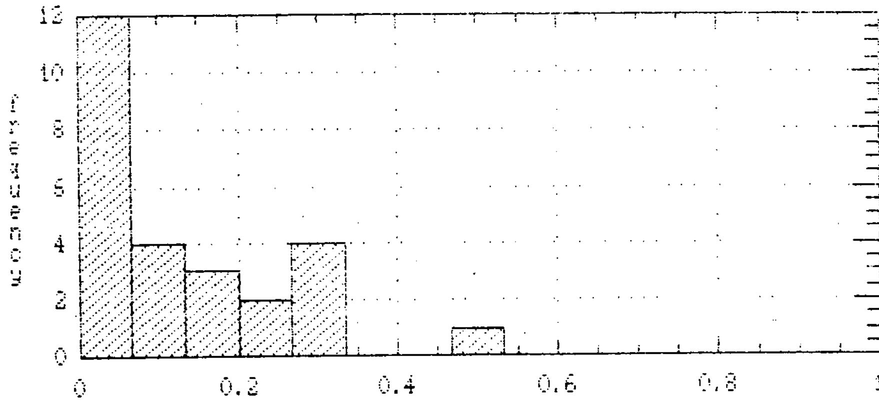



Figure 5.11

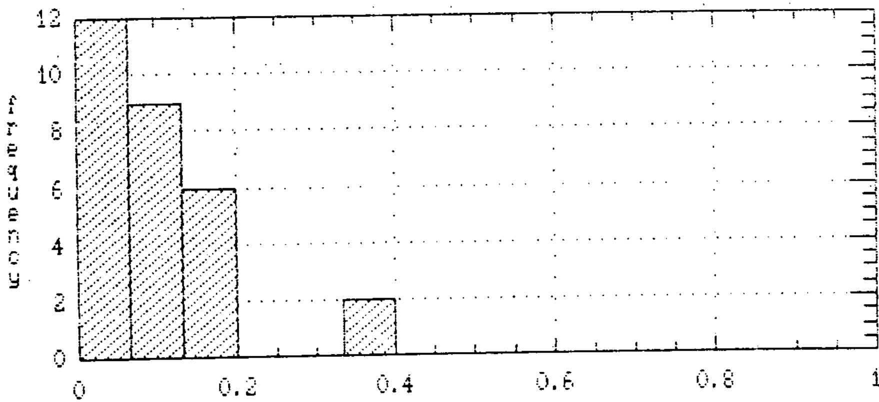
HIGHGROVE




DEMANDINGS/TOTAL 'WITH'; ALL STAFF
REDCOURT




DEMANDINGS/TOTAL 'WITH'; ALL STAFF
SEWARD LODGE




DEMANDINGS/TOTAL 'WITH'; ALL STAFF
COMPARISON WARD

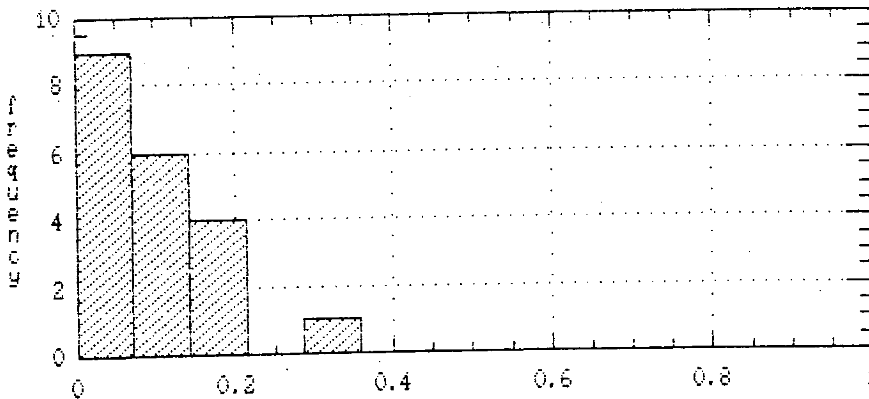



Figure 5.2

modal proportion of Demandings, as a proportion of all face-to-face care, was less than one tenth in all units. The modal proportion of Positives was also less than one tenth in two units. In Seward Lodge it was one fifth and in the comparison ward it was just over one tenth. Highgrove and Redcourt showed the widest variation in both categories. In the three study sites there was an average of 10 staff for whom more than one fifth of their face-to-face care was Positive, whereas in the comparison unit only one member of staff fell into this category. There was an average of 11.5 staff in Highgrove and Redcourt for whom more than one fifth of their face-to-face care was Demanding, whereas in Seward Lodge and the Ward, only one member of staff exceeded one fifth.

We tested the hypothesis that, at each unit and between units, the more staff there were on duty, the more Positive care was given. We excluded mealtimes from the within-unit analysis, since mealtimes were generally heavily staffed, but the care almost always counted as Routine.

The 'between units' analysis was simple. Highgrove had most staff and the second highest number of Positives, Seward Lodge had the next highest number of staff, and most Positives, Redcourt had the third highest number of staff and the third highest number of Positives, and the Ward had least of each. This is shown in Table 5.10.

| | Staff/client | Positives/client |
|---|---|---|
| Highgrove | 1.29 | 13.5 |
| Redcourt | 1.15 | 10.9 |
| Seward Lodge | 1.25 | 15.3 |
| Ward | 0.76 | 9.0 |

**Table 5.10 Staffing and Positives**

Taking each unit separately, we wanted to find out whether an increase in the number of staff on duty would lead to an increase in the amount of Positive care. In order to test for this effect, it was necessary to make two adjustments to the data sets. First, we needed to test and, if needed, correct for serial correlation. This means that we could not proceed as if every quarter-hour observation was unaffected by the previous observation; for example, if three Occupational Therapists came on duty for two hours with the aim of concentrating on Positive care, the Positive count would be high for all eight observations. However, this would not give us eight times the information received in the first observation.

Secondly, we needed to remove observations which would tend to mislead. During mealtimes staffing is usually high, but without much intention or possibility of giving a great deal of Positive care. At night, staffing is low and Positive care also low. Including night-time observations would have added spurious strength to any correlation observed between the numbers of staff on duty and the number of Positive episodes.

We wished to investigate two questions; first, did Positive care increase with staff numbers, secondly, as total staff increased, did Positive care increase at an increasing rate - that is, as more staff came on duty, was any increase greater than the average proportion of Positive care?

For computational convenience we decided to perform an initial step of adding together all the observations for a particular time of day. We ended up, for each home, with a total of 47 data points, representing non-meal and non-night times of day. Each data point, therefore, was a pair of figures, first, the number of positives recorded at a particular time on each day summed over the study week, and second the total number of staff on duty at that time, again summed over the week.

We then performed simple linear regressions of the number of staff undertaking Positive care upon the total number of staff present, correcting for serial correlation by the Durbin Watson method (Neter and Wasserman 1974). Serial correlation was high and positive in all four sites. The coefficient of determination after correction was about two thirds of its value before correction.

After correction it was 0.45 at Seward Lodge, 0.41 at Highgrove, 0.1 at Redcourt and 0.1 at the Ward. The slope coefficients were 0.24 at Seward Lodge, 0.25 at Highgrove and 0.14 at Redcourt (all these were significant at the 0.025 level; Seward Lodge and Highgrove at the 0.001 level.) At the Ward, the slope was 0.1, but not significant at the 0.05 level.

All the equations showed positive intercepts with the axis along which staff numbers were measured. This means that the equations (interpreted sensibly) implied that at very low levels of staff no appreciable amount of Positive care was undertaken - this is consistent with common sense. It also means that the proportion of care given as Positive increases as staff numbers increase.

Figure 3A shows us the relation between Positives and Totals before correction for serial correlation, and Figure 3B shows the relationship after correction, for Seward Lodge. The regression lines and confidence limits give us an initial degree of assurance that what we have observed was very unlikely to have happened merely by chance; in commonsense terms, by inspecting the figure, we can see that to the left of a Total of about 25 the number of Positives is fairly unrelated to the Total, but that it increases to the right of that point.

The slope coefficient of about a quarter at Highgrove and Seward Lodge means that as extra staff come on, about a quarter of their time is spent on Positive care, or, more accurately, that either this is the case, or the extra staff release staff already present to perform more Positive care. Overall, (again, excluding night and meal times) sixteen per cent of total staff time is spent on Positive care.

At a staffing level of about 10, some 17 per cent of care is Positive, and at a level of about 12 some 22 per cent of care is Positive. This is approximately equivalent to saying that each of these last two staff spend half their time on Positive care, compared with an overall average of sixteen per cent.

This effect is what we observed at Highgrove and Seward Lodge; the statistical findings at Redcourt and the Ward were not strong enough to

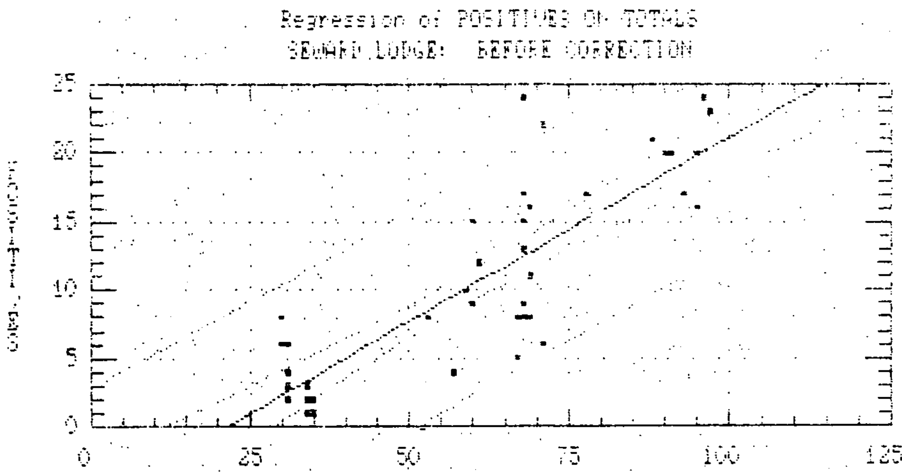



Figure 5.3a

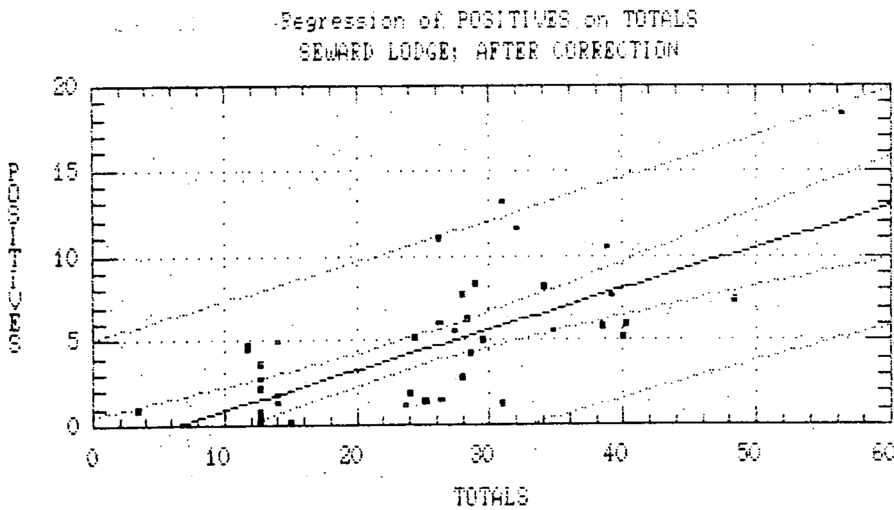



Figure 5.3b

Figure 5.3 **REGRESSION OF POSITIVES ON TOTALS FOR SEWARD LODGE, BEFORE AND AFTER CORRECTION FOR**

enable conclusions to be drawn, but at least they did not provide evidence which was qualitatively contradictory.

We could have undertaken a series of transformations of the data in order to fit a curve by least-squares methods. However we felt that the function of formal statistics in our study was more to confirm broad effects which can be observed in the data rather than to refine actual slopes, the value of which would then depend partly upon the form of the function chosen. Of course, the model linear in the data is itself an imposed functional form, but we shall try to make our conclusions broad enough to appear sensible to the reader sceptical of statistical methods.

We can summarise the findings graphically. Figures 5.4 to 5.7 show the average number of staff on duty at each site throughout the day (averaged over the seven days of the study). The work undertaken by these staff is shown divided into its four components. The top line on each diagram is total staff, the area between the top line and the next line shows staff performing tasks not-with clients, or at their breaks, the next area down shows Routine with-client care, the next area shows Demanding care, and the area between the horizontal axis and the bottom line shows Positive care.

Most staff are always present at the afternoon handover. In every unit except Redcourt this is also the peak period for Positive care. Demanding care is distributed fairly randomly with respect to staff presence - except at night at Redcourt, where predictably Demanding behaviour from a small number of residents was accompanied by the lowest number of staff, although night staffing was higher at Redcourt than the other units, mainly because the building had three storeys.

## CLIENTS AND THE DISTRIBUTION OF CARE

Having examined the relationship between staffing numbers and the type of care given, we now examine the distribution of care over the different clients. The following questions are addressed:

1. Do conventional dependency measures predict the distribution of care?

2. Was the distribution of care over clients markedly different in the four units?

3. Are there 'low cost' and 'high cost' clients, and if so, what is the magnitude of the difference?

### Dependency and care

For each home separately we undertook a comprehensive series of regressions. The numbers of Positive, Demanding and Total observations were regressed upon the scores for each individual on most elements of the Crichton Royal schedule, and upon the Total. We were asking whether classifications of, for example 'restlessness' or 'feeding independence' would give a clue to the amount of care given, and the type of care.

In only three cases did we find slope coefficients different from zero at the 0.05 level, and one of these was perverse. Given the large number of regressions undertaken, and the 0.05 significance level chosen, we would have expected to pick up two or three 'significant' results even in the

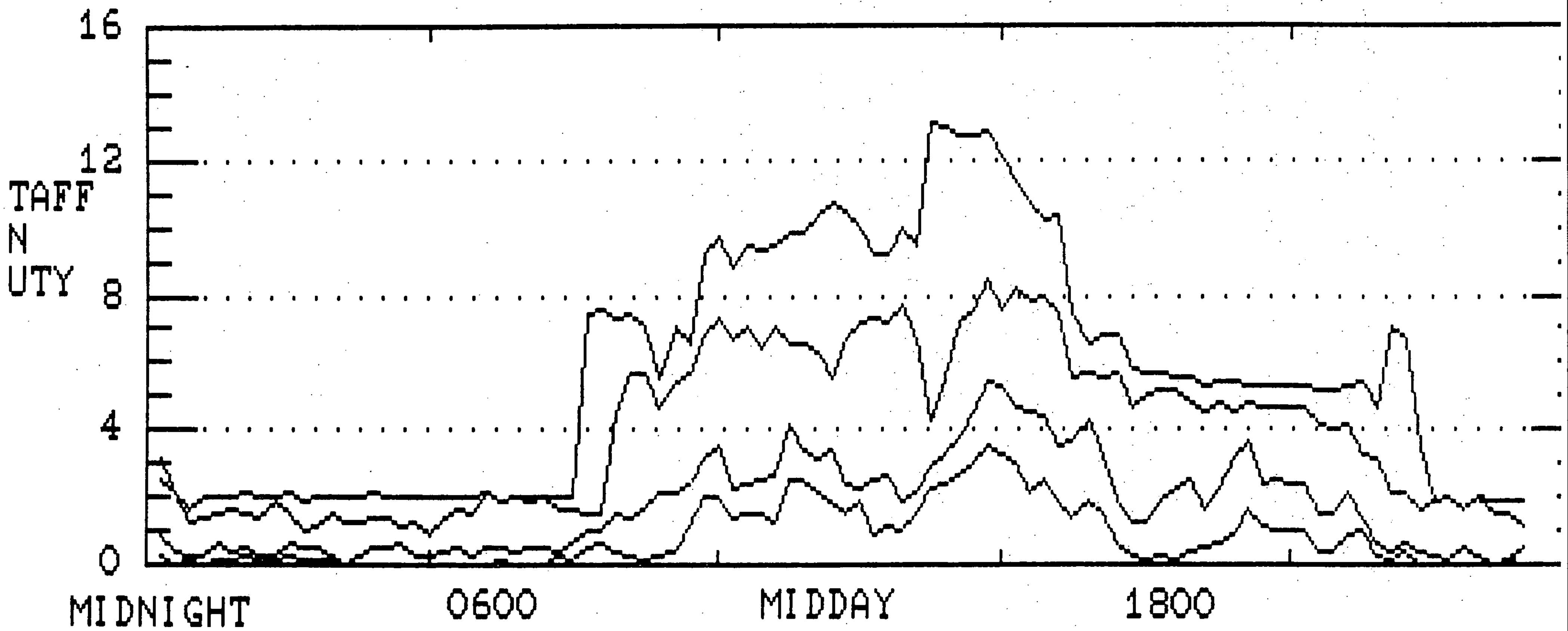



Figure 5.4 **HIGHGROVE**

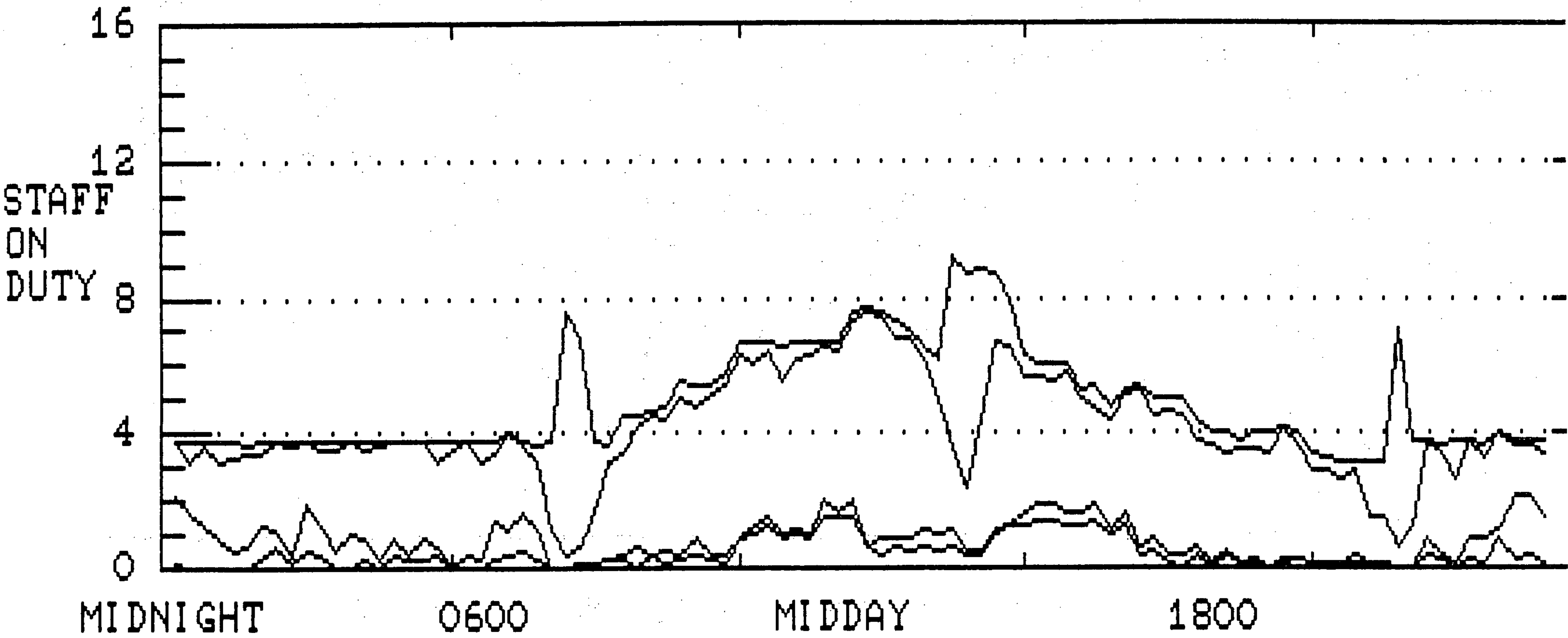



Figure 5.5 **REDCOURT**

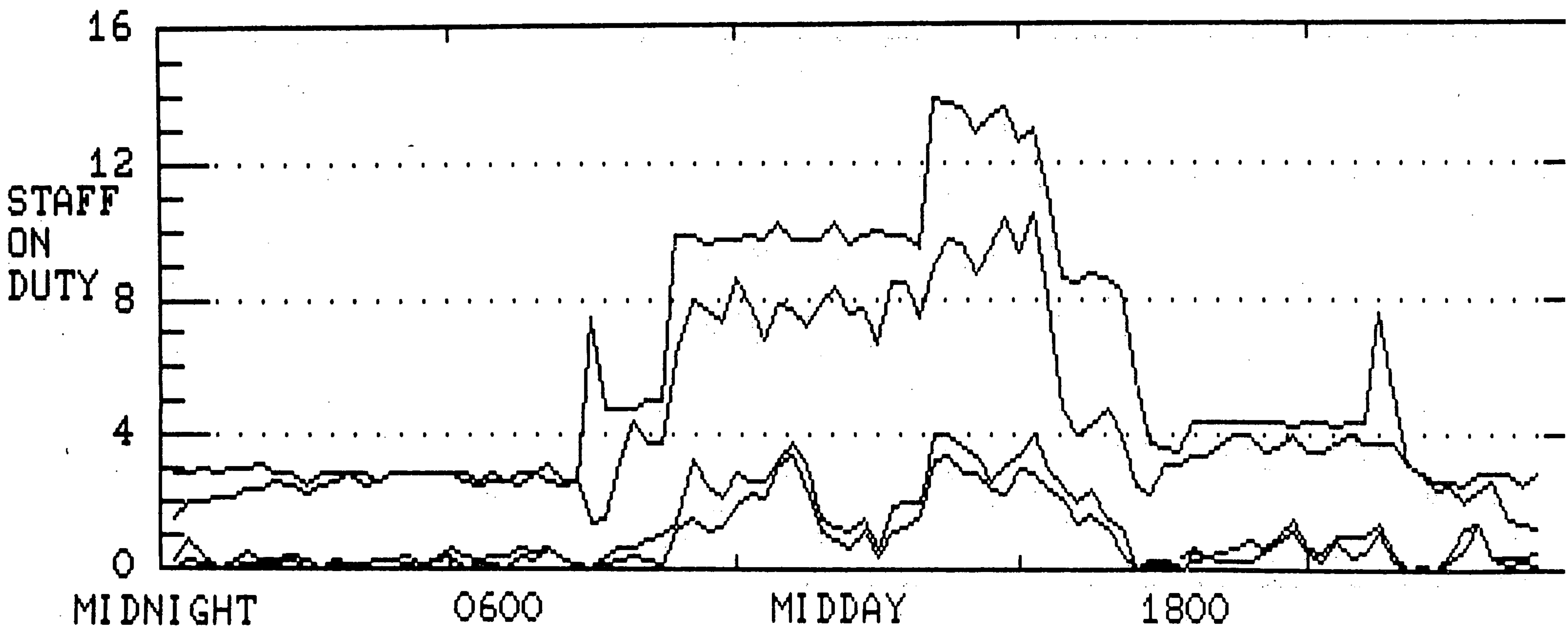



Figure 5.6 SEWARD LODGE

(relatives of) the clients who consume few staffing resources to subsidise the (relatives of) the clients who consume the most, by means of a single charge.

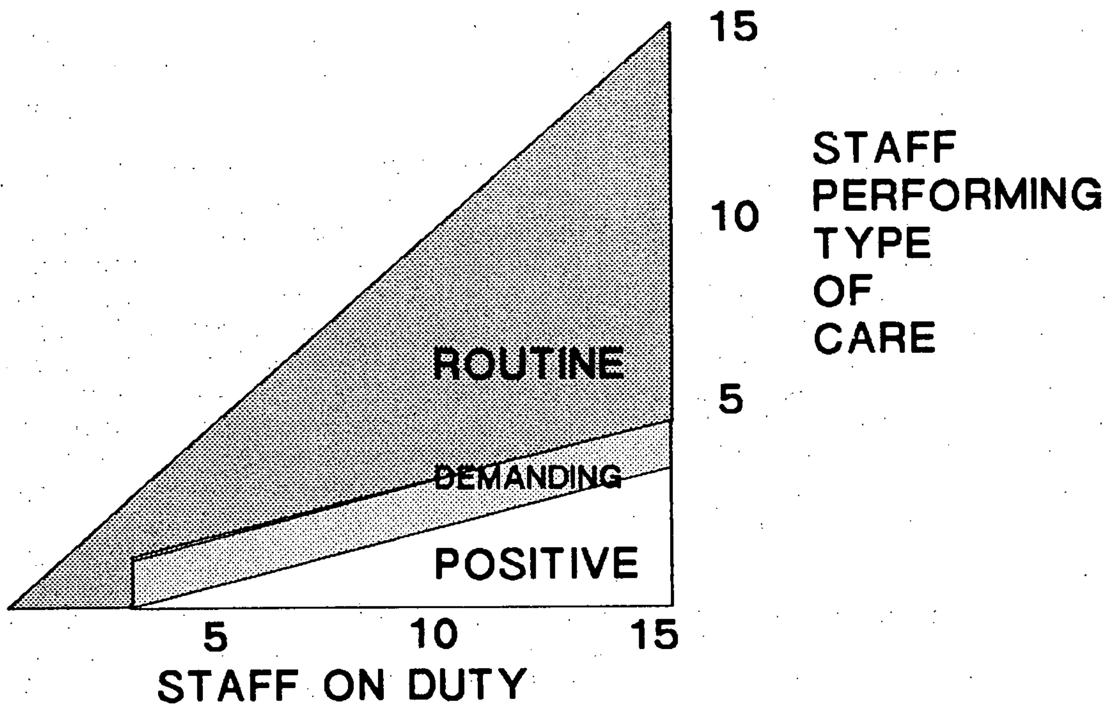
Secondly, we see that the majority of direct care is performed by untrained staff. This is true of acute nursing as well, but only when learners are present. In acute physical illness wards with no learners, most care is performed by trained staff; indeed only a very small proportion of care is performed by auxiliaries. If we compare the best staffed of the experimental homes, Highgrove, with the Ward, we see that they each possessed the same number of qualified staff. Yet sixty-two per cent of time of qualified staff at Highgrove was spent on administrative and other non-direct-care duties, compared with forty-one per cent at the Ward. There was, therefore, a substitution of untrained for trained staff. This was true for Seward Lodge also, but not Redcourt. Redcourt was, in fact, the most similar to a conventional ward, being staffed on normal health service lines, with some extra staff.

We have already explained that Seward Lodge employed no domestic staff, but that all hotel functions were performed by the generic care workers, employed on nursing auxiliary grades. The Activity study gave us data to assess the simple economics of this, although the policy was not in place to save money, but as part of a total philosophy of care. We found that the hotel work undertaken was the equivalent of three and a half full time staff. This was less than Highgrove, and much less than Redcourt; given that Seward Lodge
and the highest workload, it is probable that this policy was cost effective, even allowing for the fact that nursing auxiliaries are paid more than domestic staff. But we have to comment that this policy, justified in non-economic terms partly as an efficient method of stress-buffering, and partly in terms of holistic care, was not particularly popular among the staff who tended to complain that it was a waste of their acquired skills.

To turn now to the real essence of the study: what was the productivity of the extra labour at the three experimental homes? We have constructed a simple diagram based upon all the data reported above on pp 18 to 20. This is shown as Figure 5.12, and encapsulates graphically the message of this paragraph. As staff numbers increase, Positive care increases, but not as much as Routine care. Consider, for example, Highgrove and the Ward. The average number of staff on daytime duty at Highgrove was nine, and at the Ward, four point eight. Of those extra four point two staff, one was engaged in extra Positive care, and the other three point two were engaged in extra Routine care.

Yet we have no reason to believe that the standard of routine care at the ward was in any way unsatisfactory. No short cuts to hygiene care were adopted; all residents received appropriate nutritional care; there was a constant supply of tea, coffee and biscuits. Physical needs were monitored and attended to. So even if we assume a very considerable sampling error, we are still left with the conclusion that we could have expected from Highgrove far more extra, specialist, Positive care than was actually delivered. Daytime resources were almost doubled, but this resulted in only a twenty-five per cent increase in Positive care.

So the crucial question is, is the failure of an increase in staffing levels to deliver relatively more Positive care due to the lack of training of the staff, or the way in which care was organised, or the very nature of the job?




PROPORTION OF DIFFERENT TYPES OF CARE PERFORMED AS NUMBER OF STAFF ON DUTY INCREASES

Figure 5.12

The conclusion most palatable to the proponents of the professional paradigm of nursing (Robinson et al, 1989) would be that this is exactly what would have been expected from so unbalanced an expansion in resources. There is evidence (although limited) that a substitution of qualified for unqualified staff can actually be cost effective, so it would seem reasonable that the reverse substitution should be a waste of resources. But we do not feel that this explanation is correct. Primary nursing (or its Social Services equivalent, the Key Worker system), which is part of the professional model, was in place at all units; the qualified staff were perfectly aware of up to date thinking in their professions. Yet the qualified staff, apart from the nurses or officers in charge, were just as likely to take part in manual, not-with-clients activities (termed 'associated' care in some systems) as the unqualified staff. There was no expectation that a professional training would make a member of staff a better deliverer of 'Positive' care.

Moreover, there was a piece of evidence which was in direct opposition to this explanation. Although most staff spent less than a quarter of their time on Positive care, there were two categories of staff who spent about three quarters of their time on Positive care. These were the staff at Redcourt and Seward Lodge who were employed as activity organisers, or occupational therapy aides. There was a corresponding member of staff at the Ward, who was the OT aide in the Day Hospital which two residents attended occasionally. (These records were included in the study). These staff, five in number, and only part time, were unqualified, but highly motivated. Moreover, they were only employed for around three hours a day. Their job descriptions concentrated on the specific Positive activities of Reality Orientation, Occupational and Diversional Therapy, and excluded help with physical caring activities. They were, although only accounting for a small part of the Homes' budgets, key members of staff when present, around whose activities the homes revolved.

All the homes subscribed to the philosophy that the care of persons with dementia-like illnesses is a skill which can be taught in the manner of an apprenticeship, with emphasis on practical aspects, but without ignoring the necessary intellectual - and, indeed especially, the moral,- content. Yet this sat uneasily with an equal acknowledgement of the professionalising nature of nursing and residential social work. We feel that where clients suffer from that most stressful condition, dementia, a care model which includes a considerable element of task assignment stands a greater chance of maximizing Positive care than one which relies on personalized care alone.

## CHAPTER 6: THE CLIMATE OF CARE

A key concern within the evaluation is the quality of life of the clients of the three experimental schemes. Attention is given here to the "climate" of care, or the overall "atmosphere" in the homes. Were the common objectives of the homes, such as a homely living context, individualised patterns of care and a stimulating environment, actually achieved in practice? The following issues are addressed in turn in this chapter:

- The physical environment
- The social regime within the homes
- Privacy
- Lifestyle
- Resident autonomy
- Coping with problem behaviours
- The approach to direct care

### THE PHYSICAL ENVIRONMENT

Given that the three experimental units are essentially the permanent living places for their residents, attention is given here to whether the physical environment provides a 'homely' context in which to live. Indeed, the experimental homes were given the name "the Homely Homes" to reflect the common objective of providing a domestic, non-institutional living environment. Six dimensions were identified as relevant to the issue of homeliness in residential settings: community accessibility; privacy; independence; social interaction; institutionality; identity. These qualities were assessed using as checklist of environmental features based on an architectural checklist developed by Robinson and associates (1984). The evaluation procedure simply required the assessment of each design feature on a dichotomous scale : whether the particular feature was "homely" or "institutional" as described in vignettes provided by the assessment tool. The procedure was carried out for the three experimental units and for three comparison facilities : two local authority homes for the elderly built in the 1970's and a psychogeriatric ward in a large mental illness hospital.

Table 6.1 summarises the evaluation of the specific design features for each facility. H indicates that the facility is primarily "homely" in respect to the design feature in question, while I indicates it is primarily "institutional" in character. A space indicates a situation somewhere between the two. The summary should be seen only as a crude guide to the relative qualities of the different facilities and is simply derived by summing the scores on each dimension and no attempt has been made to assess the relative contribution of each design feature to the overall environment.

Table 6.1 Evaluation of 'Homeliness'

| | Red Court | High-grove | Seward Lodge | Home I | Home II | Hosp Ward |
|---|---|---|---|---|---|---|
| COMMUNITY ACCESSIBILITY | H | I | I | H | H | I |
| PRIVACY | H | H | H | | I | I |
| INDEPENDENCE | I | H | H | I | I | I |
| SOCIAL | I | I | I | I | I | I |
| INSTITUTIONALITY | | I | H | I | | I |
| IDENTITY | I | H | H | | H | I |

Community accessibility: Long-stay facilities for the elderly mentally ill have been traditionally provided at a few centralised locations, notably in large, isolated mental illness hospitals. However, the idea of segregating the elderly and the mentally ill is no longer seen as humane or necessary and the current emphasis is on integration within the wider community. Of course simply locating a facility in a residential area does not ensure community involvement, but at least the barrier of physical distance will have been removed. Redcourt and the two Part III homes are located in residential areas close to local amenities such as parks or shops. Highgrove, Seward Lodge and the mental illness ward are on non-residential health authority sites that are located in isolated or inaccessible places making community integration and involvement more difficult.

Privacy: Long-term accommodation can range from open hospital wards to private single rooms. Privacy also refers to whether there are private, secluded spaces, both inside and outside a facility for informal use by residents. The internal layout of homes is also important. For example, the location of "backstage" services, such as toilets and bathrooms, next to the more public spaces, such as living areas, can also compromise privacy within a home. The need for privacy is an important aspect of an individual's quality of life, even for cognitively impaired people, and is discussed in more detail in later sections. All three experimental units afford reasonable levels of privacy. However, the layout of Highgrove involves bedrooms being in close proximity to social and circulation spaces. This may limit seclusion and privacy, but may also afford better social integration of less mobile residents.

Independence: Are residents able to be optimally independent in their residential setting? Both Highgrove and Seward Lodge are rated as homelike in terms of promoting independent living. Residents have access to housekeeping facilities if they want to and the layout of the building does not prohibit the informal use of outside areas and private rooms. However, the situation is fairly marginal. The large scale of the buildings and the needs for corridors and a complex building layout often prohibits independent action by confused people. Homelike qualities such as small kitchens may promote participation in domestic tasks. However, laundry facilities tend to be spatially separate making these less accessible for participation by residents. Overall, the environment of Redcourt may inhibit independent behaviour amongst residents as there are few

opportunities for residents to do things for themselves, compared with Seward Lodge and Highgrove.

The social environment. Social interaction is in some ways structured by the phsyical environment. for example, people with sensory defecits may find communication difficult depending on the particualr acoustic or visual environment. Layout is also important and all the facilities are rated as institutional on this dimension. The scale of provision is significant factor here. Large living areas, communal eating areas and peripheral seating arrangements are still the norm, which detract from the quality of intimacy that is important in social interaction.

Institutionality. The physical environment has important symbolic attributes as well as purely functional ones. To what extent do the building, fittings and decor communicate and reinforce an image of institutionalisation in the minds of users? Overall, the site and appearance of Redcourt are more homelike that for Highgrove or Seward Lodge. However, the interior layout and treatment of Seward Lodge and Highgrove are less institutional than Redcourt. It is difficult to say whether a facility has an institutional or homely 'atmosphere'.

Identity. To waht extent do residential environments afford a sense of individuality, self determination and personal dignity to the client. The scale of all the facilities in the survey was large, and communal living tends to limit the expression of personal identity. However, the scope for personalisation and individuality in all the facilities except the hospital is fairly high. The availability of individual rooms is an important factor in preserving in preserving individuality and self-identity in residential settings. Redcourt is different to Highgrove and Seward Lodge in that half the residents share rooms and some rooms accommodate more than two residents.

The results of the evaluation suggest that all the facilities involve a high degree of institutionality. This is particularly the case with the ward in the mental illness hospital, which is defined as institutional on all the six categories in the summary table. The Part III homes are more homely in certain respects, notably community accessibility and the scope for the expression of identity through personalisation. However, both these facilities are rated as institutional in respect to the scope both privacy, the promotion of independent living, the social environment and the institutional qualities of design features. Seward Lodge is rated as least institutional of the facilities, although even there the dimensions of community accessibility and the social environment are defined as institutional. Highgrove represents an intermediate case, being rated as less than ideal in respect to community accessibility, the social environment, and the institutional character of the building. Overall Redcourt is institutional in terms of its physical environment, although community accessibility and privacy are adequate.

Common design features. A number of design features are common across all units surveyed. All the facilities are in reasonably secluded locations, according the privacy that is essential to homeliness. However, it should be borne in mind that seclusion may detract from community accessibility. All other design features are institutional rather than homelike in character. In respect to resident independence, all the units have long corridors and at a scale that makes it difficult for EMI clients to find their way around. The relatively large scale of all the units also contributes to an institutional environment in other ways. For example, the distance from bedrooms to

areas for personal hygiene (washing and toilet) tends to undermine the individual's privacy. Living in large communal environments also contributes to depersonalisation of the individual residents.

Design features common to the experimental units. All three units had good access to usable grounds. For example Seward Lodge has a perimeter fence that allows residents to muse the gardens with a minimum of supervision. Highgrove and Redcourt have small garden areas, although supervision is required at Highgrove due to a slope and steps. The comparison units have limited access to outside areas. Indeed, EMI residents typically have restricted access to outside areas in rest homes because of problems of wandering. The experimental units also offer overall higher levels of privacy than the comparison units, reflecting the availability of single rooms.

A number of conclusions can be drawn:

i) On balance, the experimental homes provided more homelike environments than the Part III homes and the hospital ward. In particular. Highgrove and Seward Lodge afford high levels of privacy, while also providing a context for independent behaviour amongst residents.

ii) Residential accommodation based on the communal living of a large number of people will be inevitably 'unhomelike' in many respects. Long corridors, offices and communal lounges are all features that are rarely found in domestic settings.

iii) It is not possible to design 'homeliness' into a place except in the superficial sense of interior decor. It is only possible to produce a building that has the potential for homeliness. Homeliness depends on how the building is used.

iv) Architects and designers still do not fully appreciate many of the issues discussed above. There is a need to develop design guidelines for the EMI residential provision and there should be greater collaboration between architects and social scientists.

## SOCIAL REGIME

In this section, attention is focussed on the nature of the social environment in the experimental homes. Specifically, are ideals such as flexible patterns of care, individuality and personal choice put into practice? The evaluation was approached in two ways. Firstly, the Institutional Regimes Questionnaire' (IRQ) developed by Booth (1985) was used to evaluate the homes in terms of four dimensions: personal choice; privacy; segregation; participation. To provide a comparative analysis, the IRQ was administered in a number of Part III homes and a psychogeriatric ward in a psychiatric hospital. Table 6.2 summarises the IRQ ratings of all the facilities along the four dimensions. Secondly, using data from the observational study, patterns of activities were examined in terms of whether daily life in the homes was flexible or regimented. Data from the psychogeriatric ward are provided as a comparison.

**Table 6.2 Evaluation of social regime**

| | Homely Homes | | | Part III Homes | | | | | | | Hosp |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | SL | HH | RC | H1 | H2 | H3 | H4 | H5 | H6 | H7 | Ward |
| Choice | I | F | F | F | F | F | F | F | F | F | S |
| Privacy | R | I | I | I | I | R | R | R | I | R | U |
| Segregation | I | I | I | I | O | I | O | I | I | I | C |
| Participation | I | I | I | D | D | D | D | D | D | D | A |

Choice: F is flexible, S structured
Privacy R is responsive, U is unresponsive
Segregation O is open environment, C is closed
Participation D is democratic, A is autocratic

Where a facility cannot be classified, it is rated as Intermediate (I).

## Personal choice

A flexible regime is one that allows residents to define their own individual patterns of daily life. Residents are generally able to get up, have breakfast, have a bath and go to bed when they wish. They are involved in planning menus and discussing matters in the home and have a choice of meals. Residents have free access to the garden or grounds. They can personalise their own rooms with furniture and their own choice of decoration. Facilities for making one's own refreshments are available. Structured regimes have strict daily routine for all residents. Choice is highly restricted over meals and personalisation of rooms is limited. Residents have little choice over clothing and few are involved in the day to day running of the home.

Most of the units covered in the survey were classified as 'flexible' regimes, including all the Part III homes and Redcourt and Highgrove. Only the hospital ward was classified as 'structured'. Seward Lodge was rated as 'intermediate'. Although there was flexibility the pattern of daily life, there were restriction in terms of menu, resident participation and the and decoration of rooms (rooms had all been decorated as part of the commissioning of the purpose-built unit). It should also be noted that bathing is usually governed 'by nature', rather than choice when residents are doubly incontinent.

## Privacy

A home which is responsive to the need for privacy allows residents unrestricted access to their own lockable private bedrooms and provide them all with somewhere to lock personal valuables. Privacy also generally entails unrestricted access to the grounds and beyond and somewhere to receive visitors in private. Unresponsivee regimes place restrictions on all these rights.

The right of privacy within residential settings, although widely recognised in theory, does not appear to be always preserved in practice. Only five of the

eleven units could offer optimum privacy. The hospital ward was classified as "unresponsive". Communal sleeping areas and a large day room afford little opportunity for seclusion. The reason why five of the units were classified as "intermediate" was due to the restrictions placed on locking bedroom doors and the lack of lockable cupboards for valuables. For example, the bedroom doors at Redcourt are fire doors and should not be locked at any time.

## Segregation

An open environment is one where the contact between resident and the wider community is maintained. Generally, residents can come and go as they please, the front door is not locked, visitors are always welcome and overnight accommodation can be found for them if necessary. Residents frequently go out of the home to stay with family, for social activities and on holiday. A closed environment is one where residents are cut-off through restrictions or lack of encouragement on these criteria.

Only two of the eleven units covered in the survey could be classified as "open", reflecting the difficulty of integrating institutional care within the wider community. However, only the hospital ward could be classed a "closed" environment. Perhaps the general pattern of "intermediate" ratings indicates a lack of encouragement, rather than active restriction. The three experimental homes are very similar to the Part III homes in respect to the segregation dimension.

Visitors are normally welcome at any time of day, payphones are the norm and overnight accommodation can usually be arranged. However, access beyond the immediate grounds usually requires permission or supervision. Day outings, holidays and live entertainment are common occurrences, participation in local clubs and societies is much rarer. One significant point is that extended visits with relatives are very rare, reflecting the abrupt disengagement between client and relative/carer after permanent admission.

## Participation

A democratic regime is one where residents are involved in the day to day running of the home. There are regular meetings between staff and residents to discuss home matters and menu planning. Residents also participate in small domestic home jobs , while staff provide frequent in-house entertainment. An autocratic regime is one where residents are excluded from the day to day running of the home.

All the Part III homes had high levels of resident participation. Staff-resident meetings were a common feature, as was home entertainment. However, residents are not always willing or encouraged to help with domestic tasks. In contrast to the Part III homes, the hospital ward had an autocratic regime with minimal patient participation. All three homely homes were rated as intermediate. Resident participation is obviously limited by the mental state of the residents. For example, it is not possible to have meaningful staff-resident meetings.

## Flexibility or Regimentation?

One of the indicators of good residential environment is a flexible, non-regimented approach to the needs of individual clients, and indeed this is

a common objective amongst the three experimental units. Conversely, a regimented approach to care is primarily task-oriented, the objective being the performance of a predefined task or job, rather than to cater for the the specific needs of the individual at any given time. Regimentation encourages care workers to treat clients as 'objects' and indeed, the individual is made to fit the institution, rather than <u>vice versa</u>. In a highly regimented pattern of care, all the major tasks of functional care will occur at the same time each day for all clients. Typically, everybody will be got up and put to bed at the same times each day, meals will occur at set times, and aspects of care such as toiletting will be performed en bloc. Activities may be restricted to particular times or days of the week.

Of course, any approach to care provision in an institutional setting will involve a trade-off between the needs of the individual and the needs of the home as a whole; between flexible and regimented patterns of daily life. There are advantages and disadvantages on both sides of the equation:

<u>Advantages of a flexible approach</u>- there tends to be a more relaxed overall "climate" within the home. There is no time when staff and residents are all involved in the same activity at the same time. Very importantly, a flexible approach allows needs to be addressed individually, where and when needed.

<u>Advantages of a regimented approach</u>- this tends to be efficient (at least in the short term) in terms of performing the routine tasks of care. A high workload can be performed by relatively few staff. The strict routine means that everyone knows generally what will be happening at any given time of the day, and staff resources can be geared to achieving these targets.

<u>Disadvantages of a flexible approach</u>- this can be quite demanding on staff, as different needs and demands have tyo be coped-with at the same time. For example, one patient may want something to eat at the time when staff may be toiletting or washing another person. Staff may never effectively 'clear the decks', that is demand for functional care will be continuous, and may be at the expense of more positive care inputs.

<u>Disadvantages of a regimented approach</u>- the clients are constrained by the regime, possibly leading the internalisation of the communal routine and attendant institional behaviour. Equally, one cannot expect individuals to comply to imposed routines. For example, the same person may not always respond to activities, such as music, in the same way every time. Also, the regimented performance of routine tasks of living may lead to long periods of purposelessness within the institution, if alternative activities are not provided.

Table 6.3 summarises data from the observation study and looks at regimentation in terms of three aspects of everyday life: getting-up and going to bed; mealtimes; and toiletting. Data are provided for the three experimental units and a psychogeriatric ward in a large psychiatric hospital. A highly regimented pattern of life would involve residents getting up together, all eating, being taken to the toilet and finally going to bed at the same time. A less regimented pattern would be much more fluid in terms of when these activities take place and which residents are involved. It should be noted that Seward Lodge, Highgrove House and the psychogeriatric ward did not provide their own main meals and that mealtimes were therefore constrained by external factors.

**Table 6.3 Regimentation of care**

| Time | Seward Lodge | | | High-grove | | | Redcourt * | | | Ward | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | s | m | t | s | m | t | s | m | t | s | m | t |
| 07.00 | | | | | | | | | | 13 | | |
| 07.30 | 11 | 5 | | | | | | | | 5 | | 3 |
| 08.00 | 11 | 1 | 1 | 8 | 1 | | 9 | | | | | 1 |
| 08.30 | 9 | 3 | 1 | 6 | | 1 | 8 | | 3 | | 10 | |
| 09.00 | 7 | 1 | 1 | 4 | | | | 7 | | | 4 | |
| 09.30 | 2 | 1 | 1 | 3 | 1 | | | 10 | | | | |
| 10.00 | 2 | | 2 | 3 | | | | | | | | |
| 10.30 | 1 | 1 | 1 | | | | | | 1 | | | |
| 11.00 | 1 | | 2 | | | | | 7 | | | | |
| 11.30 | | 7 | | | | | | 12 | | | | 4 |
| 12.00 | | 16 | | | | | | 1 | 1 | | 12 | |
| 12.30 | | 12 | | | 9 | | | | | | | |
| 13.00 | | | 1 | | 5 | | | | | | | |
| 13.30 | | | | | | | | | | | | |
| 14.00 | | | | | | | 1 | | | | | |
| 14.30 | | | | | | | | | | | | |
| 15.00 | 1 | | | | | | | 3 | | | | |
| 15.30 | | | | | | | | | | | | |
| 16.00 | | | | | | | | | | | | 1 |
| 16.30 | | 1 | | | | | | | 1 | | | |
| 17.00 | | 1 | | | 7 | | | 10 | | | | |
| 17.30 | | 5 | | | 8 | | | | | | 14 | |
| 18.00 | | 10 | | | 3 | | | | | | | 3 |
| 18.30 | | 4 | | | | | | | | | | 3 |
| 19.00 | | | | | | | | | | | | |
| 19.30 | 1 | | | | | | | | | | | |
| 20.00 | 2 | 1 | | 3 | | | | | | | | |
| 20.30 | 2 | 1 | | 5 | | | | | | | | |
| 21.00 | 3 | | | 8 | | | | | | | | |

s -number of residents sleeping in bed
m -number of residents eating meals
t -number of residents being toileted

* Redcourt includes some residents who were bed-bound, and these people have been excluded from this table

Table 6.3 indicates that the hospital ward has a highly regimented pattern of daily life. All but one of the residents were got up by staff between seven and eight, and were taken to the toilet on getting up. All the residents ate their breakfast between 8.30 and 9.30. prior to dinner at midday, residents were taken to the toilet and the meal was finished by everybody by 12.30. The evening meal was eaten by everyone between 17.30 and 18.00 after which residents were taken to the toilet. The day is characterised by predetermined slots of short duration for these specific activities and all the residents are expected to fit in with this routine. In comparison, the three experimental units show a more flexible pattern of activities. In particular, there is no specified time for getting-up or going to bed. Meals stretch over a considerable time, indicating that there is no neccesity for all residents to start and finish at the same time. Toiletting occurs throughout the day, indicating that staff are responding to individual need rather than performing the task by rote.

Discussion

Generally, the Part III homes provide reasonably positive environments for residents. All were rated as having flexible regimes and a high level of participation of residents in the running of the homes. They scored less well in terms of privacy, while only two of the seven Part III homes could be described as having an "open" environment. The psychogeriatric ward in the mental hospital was rated adversely on all four dimensions. The three experimental homes were typically intermediate on the four dimensions covered in the IRQ. However, the analysis of daily patterns of life indicated a relatively unstructured regime that accommodates the varying needs and propensities of individual residents.

The section highlights a number of issues:

i. Concepts of residential care need to be developed that are sensitive to different client groups. Generic concepts and techniques are not always appropriate in establishing what is "good" care. For example, active participation and decision-making by EMI residents is not feasible in terms of group meetings. Thus, the experimental homes are not classified as democratic as measured by the IRQ. This conceptual development is important if criteria for measuring quality of care in EMI settings are to be established. This is of particular relevence to the registration and monitoring of nursing homes catering for this client group.

ii. This last point raises the question of how personal choice encouraged and supported in places where clients are predominantly mentally impaired? In the homely homes, the operation of a keyworker system with individual care plans is aimed at individualising the pattern of care. Keyworkers act as facilitators, by understanding the needs and desires of individual clients and ensuring that these are fulfilled.

iii) Admission to residential care appears to mean abrupt disengagement from wider society and family. This is true for most of the facilities surveyed, including the three experimental homes. This underlines the point that although the units are experimental schemes looking at new ways of caring, they are still very much "homes" in the traditional sense. Further investigation of the positive and negative impact of disengagement on residents and relatives is required.

**PRIVACY**

Booth (1985) stresses the importance of individual privacy within residential settings on a number of counts. Firstly, it can shield the individual who might be vulnerable to the actions and power of others. Secondly, it offers a space for self-expression and choice, which might be restricted by the constraints of communal living. Thirdly, a private space is needed, because people who are forced to live in public "may only be able to find the privacy they need by turning in upon themselves".

These principles are embodied in the homely homes schemes, with single rooms being the norm rather than the exception. In this section, attention is focussed specifically on the use of single bedrooms as a basis for privacy within the homely homes and whether this resource actually contributes to a better quality of life.

Do EMI residents have a need for privacy?

It should not be assumed that because someone is mentally impaired that they do not have a need for privacy. A detailed investigation into this issue was undertaken at Highgrove, involving observation, interviewing staff and analysing case notes. This indicated that most residents had a requirement for privacy. Some spent a considerable amount of time in their rooms (up to 90% of time in one case). Three residents seemed to prefer being in their own rooms, often getting agitated if they spent too long away. Some residents could be found sitting alone at particular places within the home. One resident, while not liking to be alone, would dislike 'strangers' in the lounge, and would only be comfortable with residents and staff with whom she was familiar.

How is privacy regulated?

The research shows that EMI residents do have a need for privacy and secondly that the three homes do provide private spaces, notably the individual rooms. But do residents really have the opportunity for privacy within the experimental homes? An important issue here is whether residents use their own rooms for the purpose of privacy? Detailed observation of residents' activities shows a very low level of utilisation of the private bedrooms during daytime (Table 6.4).

The three homely homes all have higher rates of bedroom utilisation than do the three comparison units, which are hospital wards. However, the overall rates of utilisation would appear low, given that private rooms are a key feature of the homely homes. The exception is Highgrove House, which has a relatively high level of utilisation at 21.3%. It should be noted that four of the Highgrove residents spend a considerable amount of time in their rooms and account for some 78% of all non-sleep use of bedrooms. The use of private rooms in Seward Lodge and Redcourt is only marginally higher than the time during the day spent in shared domitories in the comparison facilities. A number of reasons may account for the low use of bedrooms by residents:

Table 6.4 Non-sleep use of rooms

| HH | SL | RC | C1 | C2 | C3 |
|---|---|---|---|---|---|
| 21.3% | 5.8% | 7.3% | 1.2% | 4.7% | 3.3% |

(Residents' non-sleep activities in bedrooms as a percentage of total activities)

C1 C2 C3 are comparison facilities. These are traditional psychogeriatric wards which have no private rooms.

i. the inability of residents to find and use their own rooms. The level of cognitive impairment of residents was generally very high, and many appeared unable to remember that they had their own room or to find it. Clearly, this precludes the purposive use of private rooms, except by the less mentally impaired. However, the cognitive assessments of residents indicate that many did recognise their own rooms when they saw them, for example, if they were wandering. This is a significant feature of the higher levels of bedroom

utilisation in Highgrove. The fact that most of the bedrooms are in close proximity to the spaces that are in general daily use means that the residents are more likely to come across their rooms by chance.

ii. the design of the building does not afford usage of private rooms. The way spaces in a a building are laid out has an impact on the way they are used. This may account for the relatively infrequent use of rooms in Seward Lodge and Redcourt. Many of the rooms at Redcourt are situated on the first floor, and once residents go down to the day room in the morning, the distance to rooms and the stairs act as a barrier to usage. The layout of Seward Lodge does not encourage the use of private rooms. These are situated on the periphery of the two residential wings, away from the general circulation areas and separated from living areas by fire doors. Significantly, the layout of Highgrove may encourage the informal use of private rooms by residents, as these are in close proximity to circulation areas and living areas.

iii. the care regime is geared towards communal living. Patterns of routine behaviour are reflected and structured by the particular uses ascribed to specific areas and rooms. For example, the typical pattern of resident's activity in the early morning was: asleep in bed; dressing; exit to living room. The great majority of residents did not use their rooms again until they went to bed in the evening. This pattern was very similar to that found in the comparison psychogeriatric wards. In general there were very few occasions where residents were taken to their rooms by staff except for functional activities, such as washing. Highgrove House was the only unit where there was a significant use of private rooms. Four of the residents were identified by some staff as "room people", in that they preferred to be alone in their own rooms. However, it should be pointed out that there is a thin dividing line between privacy and isolation. Bedrooms can potentially be "prisons" as well as "refuges" and staff need to be aware of the possibility of isolation, especially amongst those people who may have poor mobility.

Discussion

This section has called into question some of the assumptions about privacy within an institutional setting. For EMI clients, it is insufficient to simply provide private facilities within the home. There is a need to raise awareness amongst staff that privacy is an important aspect in the quality of life of residents and that residents should be encouraged and enabled to seek privacy when they so wish.

However, to put this in perspective it is worth outlining some of the benefits that accrued from having individual rooms. These views were distilled from qualitative observation and interviews with a wide range of concerned individuals (relatives, staff, outside professionals etc.) during the evaluation.

i. Dignity/rights. It is arguable that just because an individual is cognitively impaired and dependent, this should not undermine their basic rights. In the context of modern society, the traditional psychiatric ward based on communal living is no longer seen as sustaining human dignity.

ii. Territoriality. Having a "home" is an intrinsic part of human nature. Many of the residents, even though they may be unable to find their way about do recognise their own rooms as their place.

iii. Private activities. Single rooms allow activities such as personal hygiene

and dressing to be done in private. The individual can also use their own room to pursue their own activities or simply to sit and "be quiet".

iv. Institutional behavior. The physical environment provides cues for the way people behave. Communal environments both suggest and structure communal or "institutional" patterns of living and action on the part of residents and staff. The domestic arrangements of a private room provide the environmental basis for a more humane approach to patterns of living and behaviour.

v. Relatives' expectations. In the present day single rooms are increasingly seen as a right, rather than as a luxury. Certainly relatives of residents preferred the idea of single rooms as a way of preserving dignity and individuality for their relative.

vi. Individual needs. The availability of single rooms meant that individual needs could be dealt with more flexibly. At Highgrove some individuals appeared to benefit from being in their own rooms for much of the day. Moreover, more able individuals are able to proactively use their rooms as they wish.

vii. Individualised care. Single rooms allow individualised patterns of care without disrupting other individuals. Washing and dressing can be done without disruption. Individual patterns of sleeping and waking are also more easily achieved.

## A POSITIVE LIFESTYLE

The emphasis in the three experimental homes is on maximising the quality of life of the individual residents. The homes should provide contexts that are conducive to a more fulfilled life than is usually the case for this client group. The observational study provided considerable insight into the daily lives of the residents in the three homes A number of issues were explored in the this section as pertinent to the idea of a positive lifestyle,

- positive activities
- passivity
- negative activities

Table 6.5 summarises the observational data of residents in term of these three categories. The table shows the percentage of clients' total waking time that is spent on specified activities. The comparisons are traditional pshychogeriatric wards in hospitals.

**Table 6.5 A Positive Lifestyle?**

| | Homely Homes | | | Comparisons | | |
|---|---|---|---|---|---|---|
| | Seward | Red-Court | High-grove | C1 | C2 | C3 |
| Leisure | 5% | 10% | 9% | 2% | 1% | 16% |
| Social interaction | 20% | 5% | 10% | 11% | 9% | 6% |
| Total: Positive activities | 25% | 15% | 19% | 13% | 10% | 22% |
| Asleep during day | 8% | 15% | 15% | 17% | 21% | 5% |
| Doing nothing | 34% | 27% | 38% | 33% | 40% | 39% |
| Total: Passive activities | 42% | 42% | 54% | 50% | 61% | 44% |
| Wandering | 11% | 4% | 4% | 11% | 2% | 0% |
| Deviant behaviour | 4% | 8% | 2% | 2% | 6% | 6% |
| Total: Negative activities | 15% | 12% | 6% | 13% | 8% | 6% |
| Total: Other | 18% | 31% | 21% | 24% | 21% | 28% |

Positive activities

Positive activities are defined here as those activities which generally enhance the well-being of residents. The observational study provided data on leisure and social interaction, both of which can be seen to contribute to a high quality of life. Leisure includes group activities organised by staff, one-to-one activities and informal leisure pursuits, such as watching television, reading and singing. Social interaction is any activity where the primary objective is communication between people for its own sake, rather than any instrumental objective. This includes both conversation and non-verbal communication, such as touching or gersturing.

Table 6.5 summarises the time spent on positive activities by residents. For the three experimental units and the three comparison units, the time residents spent on these positive activities ranged from 10% of waking time at one of the comparison facilities to 25% at Seward Lodge. Given the emphasis in the three experimental homes on enhancing residents' quality of life, it is important to point out that comparison unit #3 has a level of positive activity that is similar to Seward Lodge and higher than both Redcourt and Highgrove. The figure of 15% of residents' time at Redcourt is only marginally higher than the level at comparison unit #1. There are interesting differences between the various units. For example, the high level of positive activity at Seward Lodge is largely due to high levels of social interaction, while the situation is reversed in comparison unit #3. It is worthwhile looking at these differences in more detail. Table 6.6 summarises the nature of all social interactions in the three homely homes and comparison unit #1.

Table 6.6 Social Interaction

| | Seward Lodge | | High-grove | | Redcourt | | Ward | |
|---|---|---|---|---|---|---|---|---|
| Resident-resident | 116 | 15% | 39 | 5% | 1 | 0% | 25 | 7% |
| Resident-staff | 39 | 5% | 40 | 4% | 17 | 4% | 18 | 5% |
| Total observations | 814 | | 1069 | | 410 | | 384 | |
| Resident-staff ratio | 3.5:1 | | 2.7:1 | | 2.6:1 | | 3.3:1 | |

The first observation on this data is that the level of social interaction between residents and staff in the units is remarkably consistent between the three units, accounting for either 4% or 5% of residents' waking time in each case. This rate seems to be independent of the actual staff-resident ratio. Thus any variations in social interaction is due to interactions between residents and other residents. Table 6.6 shows a relatively high rate of interaction between residents at Seward Lodge, whereas the observed level at Redcourt is negligable. It is not clear why these variations occur. The high level at Seward Lodge is not due to the presence of day-attenders, which is a distinguishing feature. The level of social interaction at Seward Lodge is 22% for day attenders is only marginally higher than the 19% for residents. It is possible that the pattern of social interaction may reflect different levels of cognitive impairment within the different units.

Passivity

One of the major criticisms of institutional life is the low level of resident activity that is often encountered in residential settings. This may reflect both the clients' wishes and capabilities, which must be respected. However, the lack of stimulation and things to do may lead to enforced idleness and passivity. Table 6.5 provides data on passivity in terms of "doing nothing" and "inappropriately asleep". The former category includes all waking time where there is no apparent activity on the part of the resident. "Inappropriately asleep" refers to the resident being asleep during the day after they have risen and before they go to bed.

Although it may be incongruous to call "doing nothing" an "activity", Table 6.5 clearly shows that it is the single most important usage of the waking time of residents in all the units. In all "passive" time accounts for between 41% and 61% of residents' time. This is considerable more than the time spent on positive activities in all the units. Although Seward Lodge and Redcourt have the lowest levels of of passivity, it should be pointed out that Highgrove has a relatively high level of passivity, while comparison unit #3 has a level similar to that of Seward Lodge and Redcourt.

Negative Activities

Table 6.5 includes time spent on negative activities, specifically, "wandering"

and "deviant behaviour". Wandering here is defined as purposeless walking within the home, while deviant behaviour includes antisocial behaviours such as verbal and physical abuse, shouting and screaming. A high prevalence of negative activity could be seen to indicate home in which residents needs reamin unfulfilled, leading to boredom and frustration. The figures range from 6% of residents' waking time at Highgrove and comparison unit #3 to 15% at Seward Lodge. Again it is difficult to point to the reasons behind these differences. Moreover, one should consider that a high level of negative activity could indicate a non-repressive regime as much as one that fails to meet the needs of the residents. However, it is worth pointing out the very low level of negative activity at Highgrove, where clients had all been labelled as management problems prior to admission.

Differences between individuals

The broad figures for resident activity hide considerable variations between individuals in the three units. Indeed, heterogenity, rather than homogeneity is the rule in all categories of residents' activity. This is illustrated in Table 6.7 which shows observational data on the activity of residents at Seward Lodge. The figures are the toatal number of observations for each individual on each activity categories Standard deviations are consistently high and the variations at the individual level are clear for most activity categories. For example, social interaction for individuals two individuals at Seward lodge accounted for almost half their day, while for four others no social interaction was observed at all.

| Leisure | Social inter. | Asleep inapp. | Doing nothing | |
|---|---|---|---|---|
| 0 | 3 | 3 | 10 | |
| 12 | 1 | 1 | 8 | |
| 3 | 2 | 0 | 14 | |
| 8 | 1 | 2 | 7 | |
| 13 | 0 | 0 | 8 | |
| 1 | 2 | 4 | 10 | |
| 4 | 1 | 4 | 11 | |
| 0 | 2 | 5 | 11 | |
| 0 | 5 | 8 | 12 | |
| 6 | 2 | 1 | 6 | |
| 12 | 1 | 1 | 3 | |
| 1 | 1 | 1 | 10 | |
| 9 | 2 | 2 | 7 | |
| 10 | 0 | 1 | 6 | |
| 0 | 0 | 1 | 16 | |
| 9 | 0 | 0 | 5 | |
| 2 | 2 | 7 | 8 | |
| 7 | 2 | 3 | 8 | |
| 2 | 2 | 1 | 7 | |
| 5 | 3 | 0 | 9 | |
| 5.2 | 1.6 | 2.3 | 9.0 | average |
| 4.4 | 1.2 | 2.3 | 3.0 | standard deviation |

The most consistent activity across individuals was doing nothing. Overall, this is the most common use of time and is reflected at the level of the individual. These patterns are also apparent in the data for Highgrove and Redcourt. Perhaps the individual differences are even more exaggerated. For example at Highgrove House, one resident spent two-thirds of her time doing nothing.

A multidimensional scalogram analysis (MSA) was undertaken to examine whether residents could be grouped according to their patterns of activity. The MSA looks at the activity profiles of each resident and then groups them together on graphical output according to similarlty. For example, all those residents who were highly dependent, with low social interaction, and who were frequent wanderers would be close together on the MSA plot. The MSA, however, did not show any clear groupings indicating that patterns of resident activity are fairly idiosyncratic.

## Conclusions

A number of conclusions can be drawn from this section:

i. There was a high level of passivity in all the units surveyed, including the experimental homes. Levels of passivity far exceeded positive activity in all cases.

ii. The experimental homes taken together fared no better than conventional pshychogeriatric wards in reducing levels of passivity and promoting positive activities.

iii. There are considerable differences at the level of the individual. Clearly, resident mix will have a significant impact on the patterns of activity, rather than the care environment per se.

## INDEPENDENCE OR DEPENDENCE

The question addressed in this section is how far do the experimental homes encourage and facilitate residents to realise use their remaining capabilites to their full potential. The observational study provided data on tasks of living, such as toiletting, eating, dressing and washing. Table 6.8 summarises this in terms of independent self-care and dependent care for the three homely homes and three psychogeriatric wards as comparisons.

**Table 6.8 TASKS OF LIVING: DEPENDENT OR INDEPENDENT?**

| | ACTIVITY | SL | RC | HH | C1 | C2 | C3 |
|---|---|---|---|---|---|---|---|
| 1. | Independent self-care | 10% | 9% | 13% | 12% | 12% | 19% |
| 2. | Dependent care | 6% | 16% | 7% | 10% | 7% | 4% |

Together independent self-care and dependent care account for between 16% and 25% of residents' waking time. Indeed, this is the range occuring within the three experimental homes, with Seward Lodge at 16%, Redcourt at 25% and

Highgrove at 20%. The three comparison units range from 19% to 23% of residents' waking time.

Overall, independent self-care takes up more time than dependent care, with the highest ratio of 19:4 at comparison unit #3. The only exception to this pattern is Redcourt, where there is a higher level of dependent care compared with independent self-care. The other two experimental units follow the overall pattern with ratios of 10:6 at Seward Lodge and 13:7 at Highgrove.

The great majority of time allocated to independent self-care was eating and drinking, while other self-help activities were negligable. Most of the highly mentally impaired individuals were able to perform this activity to some extent. The level of care activities other than feeding, such as toiletting washing and bathing, grooming and dressing were low and where these occurred, they were generally a matter of dependent care in conjunction with a member of staff. The higher rate of dependent care observed at Redcourt may be accounted for by a greater proportion of feeding involving staff help.

The overall conclusion is that, beyond being able to feed oneself, there is very little resident autonomy or independence in terms of performing tasks of living. This conclusion should be seen in the context of the modern ethos of promoting independence amongst disabled groups such as the the elderly mentally ill.

But is this a matter of residents being inherently unable to perform most tasks of living, or is it a matter of "induced dependency", where the institutional environment does not encourage or even precludes independent action on the part of the clients? This question was addressed in the qualitative research undertaken in the present evaluation, mainly drawing on unstructured interviews and discussions with members of staff.

Interviews in the three homes during the course of the evaluation pointed to differences of opinion over this issue. A number of staff felt that they did too much for residents, making them more dependent on staff. The opinion that it is often quicker and easier to do something for a resident rather than help them to do it themselves appears in the accounts of staff in the three homes.

An interesting illustration of "induced dependency" came out of a discussion with the keyworker of a female resident at Highgrove. The resident had recently come back from a week-long holiday with a few other residents and their keyworkers at a cottage on the south coast. A considerable change had been noticed in this woman:

"Mrs X, after they had had a drink of tea, she knew that she was in a nice big kitchen and she collected all the cups together and washed then up. She hardly ever does that when she is here in Highgrove. She didn't carry on with it when she came back" (keywroker).

This raises a major possibility: that even people who appear very confused and dependent can maintain some level of awareness of their situations and to act appropriately. This particular woman spent most of her day wandering around the corridors of the unit and was certainly rated as severely cognitively impaired and dependent on the scales used in the present study. It may be that a resident's actions and behaviours are in some way structured by the social and physical context. It was not possible to systematically research this issue within the evaluation framework and, of course, the above

example represents just a single case. However, interviews with staff in the homely homes and in a number of Part III homes elicited similar accounts: that EMI residents will respond appropriately to truly domestic settings, such as the holiday cottage. This can be compared with "institutional" settings where staff perceive a common problem in "trying to get them to do anything at all".

The inference to be made here is that despite the attempt to provide a "domestic" setting that promotes independence, life in the three experimental homes remains inherently "institutionalised". This echoes Tim Booth's argument that:

"...the differences between regimes are little more than a veneer on the massive uniformity of institutional life. The common features of residential institutions are so dominant in their effects as to mask or suppress any influence that small differences in the social environments of homes exert" (Booth, 1986, 234).

## COPING WITH PROBLEM BEHAVIOURS

A specific admission criterion for Highgrove House was that potential residents had been classified as "management problems", who could not be contained within conventional Part III settings or within the community. In light of this, it is worth focussing on the way staff at Highgrove have attempted to cope with a group of residents who are characterised by wandering, aggression, and a range of anti-social behaviours.

Interviews with senior staff record that prior to admitting any residents there was a very real worry that it would not prove possible to cope. However, senior staff at Highgrove point to their perceived ability to cope with very difficult clients as a measure of the home's success. Indeed, a common observation made by visitors to Highgrove and relatives of residents, is how "normal" the atmosphere actually is. This has been achieved without recourse to physical constraint, locked doors or high levels of medication and with a body of staff who are largely young and unqualified.

It is not possible here to cover in detail the specific responses to the whole range of problems encountered within Highgrove. Rather, a broad outline of the way the specific problem of wandering residents is tackled is presented to illustrate the Highgrove philosophy and approach.

Wandering is a problem that is commonly encountered in homes that cater for cognitively impaired residents. Although common, residents who continually wander are usually seen as a serious management problem. This was very much the case in Buckinghamshire, where a number of referrals to Highgrove related to individuals who were persistent wanderers. An examination of these cases suggests that the staff and managers in residential homes did not always appreciate the nature of the problem of wandering, which in turn limits how they respond to the individuals who are presenting the problem. Staff in homes often focus on the symptoms of a problem, such as wandering behaviour, and then try to solve this by some form of short-term intervention. By focussing on the symptoms, all wanderers are seen in the same terms, whatever the motives and origins of the behaviour. This lack of discrimination means that uniform responses are made, rather than responses that are geared to a particular individual and situation. Typically, wandering residents have to be constained by locked doors or sent to a secure environment.

In contrast to this constraining approach, Goodwin and Mangan (1985) maintain that EMI patients on a long-stay ward who were allowed to come and go under an organised wandering, became less inclined to wander, more settled and benefitted from a change of scene. Similarly, Highgrove operates an "open-door" policy, where residents are allowed to wander freely under supervision.

Interviews with Highgrove staff suggested that three types of "wanderer" were encountered in the home:

i. Determined escaper. It was felt that Highgrove could not cope with every type of person. Some people have a specific reason for wanting to be elsewhere. This may reflect patterns of living from earlier in their lives, such as making meals at particular times. However, coupled with this is a persistent and strong determination by the individual to carry out their purpose. It proved impossible to contain such individuals at Highgrove.

ii. Purposeful wanderer. These people have a specific purpose when they wander, as with the previous group. However, they do not appear to have the same determination as the first group. They can be distracted from inappropriate behaviour by involving them in some other activity. Staff felt that some residents did retain a degree of insight and would respond to having the situation clearly explained to them. The Officer-in-Charge at Highgrove gave an example of individuals who were described in identical terms when referred to Highgrove from a home that was unable to cope with their wandering. During the subsequent assessment period it became clear that one of the individuals was a "determined escaper", whilst the other presented no problems given appropriate care. Understanding the history of the individual can give clues as to the reasons behind the wandering and observation can point to regularities in behaviour. This type of knowledge is helpful in determining the sort of interventions by staff.

iii. Non-purposeful wanderer. This is where the individual has no specific motivation for wandering, which can be attributed to non-specific causes, such as agitation, boredom or a simple desire for a change of scene. It is perhaps natural that people who come across locked doors want to get through them. It is equally unnatural and irritating to a person that they should not come and go as they please. Although this did result in some disruption in the nearby Health Authority headquarters, few real problems were encountered. The removal of constraints on residents was seen to have the benefit of reducing agitation and creating a more relaxed atmosphere within the home.

Although the discussion has focussed on the specific problem of wandering, some general conclusions can be drawn:

i. Dealing with problem behaviours must begin by understanding the individual and the situation. This understanding provides a basis for defining appropriate interventions.

ii. Understanding the situation and the individual makes it also possible to define the limits of what can be achieved with that individual.

iii. Whether a particular behaviour is classified as a "problem" depends very much on the ethos within the residential home. What is seen as unacceptable behaviour in one home may be taken as a normal part of everyday life in another. dealing with "problem behaviour" might be as much a matter of changing staff attitudes as changing residents' behaviour. However, no single

model of care will be appropriate to the needs of all people. The value of having a specialised EMI home is apparent here, as EMI residents can be dealt with on their own terms, rather than as "problems" within a home that is geared up for residents who are not cognitively impaired.

## APPROACHES TO DIRECT CARE

For many of the clients in the study, the main direct contact with staff is through functional care, while social care is often minimal. For those people who are severely mentally impaired, functional care such as bathing or feeding can be an important focus for interaction with staff, that is more than simply instrumental. This quality of staff-resident interaction often occurs at a non-verbal level, especially where the communication abilities of the resident are impaired. However, in this section attention is focussed on the speech that accompanies the direct care provided by staff.

Table 6.9 shows the incidence of speech accompanying direct care in relation to the total number of direct care interventions (positive, routine and demanding) that were recorded in the observation study. It should be pointed out that this data is not available for Highgrove House, and that this element of the observation study refers to Seward Lodge, Redcourt and a psychogeriatric ward.

**Table 6.9 Direct Care Interventions: Incidence of Accompanying Speech**

| | Seward Lodge | | Redcourt | | Comparison | |
|---|---|---|---|---|---|---|
| | staff interventions | | staff interventions | | staff interventions | |
| | speech | total | speech | total | speech | total |
| Demanding | 9 | 14 | 2 | 2 | 5 | 5 |
| Routine | 24 | 49 | 41 | 47 | 17 | 35 |
| Positive | 21 | 24 | 41 | 41 | 14 | 14 |

The table shows that for both demanding and positive care, the care activity is generally accompanied by speech on the part of the carer. This is not the case with routine care where the it is less frequent. There are also clear differences between the three establishments. In the case of Redcourt, the majority of routine care is accompanied by staff speech, while for Seward Lodge and the comparison unit, the rate is approximately 50%. Also, unlike the other two units, Seward Lodge has lower levels of speech accompanying demanding and positive care.

As well as the incidence, it is also necessary to look at the nature of accompanying speech. The great majority of staff speech fell into five categories: social; directing; asking; placating; discussing. Table 6.10 summarises the accompanying speech in relation to demanding, positive and routine care.

**Table 6.10 Nature of accompanying speech according to type of care intervention**

| Nature of care | Nature of accompanying speech | number of observations Seward Lodge | Redcourt | Comparison |
|---|---|---|---|---|
| Demanding | social | | | |
| | directing | 9 | | 9 |
| | asking | | | |
| | placating | 3 | 2 | |
| | discussing | 2 | | |
| Routine | social | | 28 | 3 |
| | directing | 15 | 6 | 11 |
| | asking | 5 | | 2 |
| | placating | | 4 | |
| | discussing | | | |
| Positive | social | 21 | 37 | 14 |
| | directing | | | |
| | asking | | | |
| | placating | | | |
| | discussing | | | |

As could be expected, the speech accompanying positive care was invariably social in nature. The nature of speech accompanying demanding and routine care presents a more complex picture. In respect to demanding care, it is difficult to draw firm conclusions, due to the low number of observed occurrences. However, there appears to be variations between the three units. At Redcourt demanding interventions were accompanied by placating speech, while at the comparison unit, speech was directing in nature. At Seward Lodge, both types were observed in relation to demanding care, together with an element of discussion. These three categories of speech can be seen to represent different strategies or approaches to demanding situations:

<u>directing</u>- an autocratic approach, where residents are ordered or told to act in a certain way

<u>placating</u>- difficult situations are defused by trying to calm the person down, by comforting someone who is hurt or upset, or by diverting their attention

<u>discussing</u>- people who are being aggressive or upsetting others are reasoned-with in order to divert deviant behaviour

The speech accompanying routine care is particularly interesting, for the reasons outlined above. Within the comparison unit, the nature of the speech is largely directing in nature, although there was a small incidence of social and asking speech. At Seward Lodge, routine care was accompanied by directional speech or by asking questions, both being aimed at the performance of the task. At Redcourt, routine care was normally associated with social speech, together with some directing and placating speech.

In general, accompanying speech tends to be task-oriented, in that the nature of the speech reflects the nature of the direct care intervention. Thus, <u>positive care</u> is generally accompanied by <u>social</u> conversation, in order

conversation is usually the prime focus of these interventions. Demanding care is invariably accompanied by diversional speech, that is aimed at ameliorating a difficult situation or specific problem. Finally, routine care tends to be accompanied by instrumental speech that contributes directly to the performance of the care task, although the actual level of accompanying speech tends to be lower for routine interventions. The major exception to these broad trends is the performance of routine care at Redcourt, where the quality of the interaction is enhanced through non-instrumental speech. At Redcourt, assistance with the everyday tasks of living are as much an opportunity for positive, life-enhancing interaction as they are part of the daily routine.

## CHAPTER 7: OUTCOMES OF CARE

High quality care or a good living environment do not necessarily mean that the client will subjectively experience a high quality of life. Thus, it is important to pay attention to the outcomes of care provided in the three experimental homes.

The issue of care outcomes presented some problems in the context of the present research. Firstly, the research approach was primarily descriptive and the experimental design that is required for making firm conclusions was not feasible. Thus, this section can only be taken as an indication of outcome, rather than as hard "results". However, we feel that the information produced by the research is of sufficient strength and relevence to warrant serious consideration. Secondly, a common way of measuring outcome is to elicit the opinions of the service consumers. This was impossible here as consumers were in most cases unable to comprehend questions or articulate responses. In the course of the research, it became clear that a number of measures are needed in the evaluation of outcome of a residential service for the elderly mentally ill. The following were examined as part of the evaluation:

survival

psychological well-being

dependency

attitudes of relatives

### SURVIVAL

One of the unanticipated issues to arise in the research was the longevity of the residents and it is valuable to examine the patterns of mortality in the experimental homes. Table 7.1 summarises the numbers of deaths over the two year period April 1988 to April 1990 for the three experimental homes and comparison samples drawn from a number of Part III homes and one ward in a psychiatric hospital.

The figures in Table 7.1 show lower mortality rates for the homely homes than the comparisons. Moreover, mortality in previous years at Highgrove and Redcourt was even lower. Obviously, these are very crude figures. The relatively small samples and the lack of strictly controlled comparison groups are limiting factors on statistical analyses. A chi-square test indicates that there is no statistically significant difference between mortality rates. However, all three experimental homes showed lower mortality rates than the comparison facilities. This does not appear to be an effect of age structure or dependency levels compared with other units, as residents in the experimental homes were, on average, older and more dependent than those in the comparison units (see earlier section).

Table 7.1 **Mortality in Homely Homes and Comparison Units (April 1988-April 1990)**

| | No. Residents | Deaths No. | % |
|---|---|---|---|
| Highgrove | 15 | 6 | 40% |
| Seward Lodge | 20 | 4 | 20% |
| Redcourt | 21 | 11 | 52% |
| Pt III | 11 | 7 | 64% |
| Ward | 14 | 11 | 79% |

Conclusive statements on mortality will require further research, using multivariate techniques with a better data set. We feel that this is an important area for future study as the extension of lifespan is certainly a factor that has resource implications.

Low mortality after opening

An interesting aspect of survival was the very low death rate amongst residents in the early months after the opening of the experimental units. There were no deaths at all amongst the residents of Redcourt during the first eighteen months although there have been eleven deaths since. At Highgrove only three deaths were recorded in the first 48 months of operation, while seven residents died in the following year. The longevity of residents was explained by a senior member of staff at Highgrove in terms of:

"...[the ones who have died], they were all a lot older and frailer. We did as much as we could for them, but we couldn't hold the flood gates back any more".

The implication is that dementia involves progressive deterioration that will eventually lead to death. However, the care environment at Highgrove provides the level and kind of support that will maximise the person's survival. During the course of the research residents would often be identified as being near to death, either through illness or accident, yet would recover their health and fitness, often to the surprise of staff. Annual reviews of individual residents frequently praise keyworkers for their work in these situations. It should also be remembered that the direct care provided at Highgrove is supported by a multidisciplinary team that includes a medical officer and a range of therapists.

Differences between residents and day attenders at Seward Lodge

The most interesting comparison to be made is between the residents and day attenders at Seward Lodge. Table 7.2 summarises the characterisitics and crude death rates of the two samples. The data are for Seward Lodge clients who were in place on 30th April 1988 and data on dates of decease are available for the two years up to 30th April 1990. The difference in the death rate over the two year period is clear, with the rate for day attenders

(58.6%) being over twice as high as that for residents (23.8%). A crude measure of overall dependency is provided by the Chrichton Royal assessments which show that residents are significantly more dependent than day attenders (t=3.22, significant at the 1% level), which indicates that residents are, on balance, frailer than the day attenders. Thus, the death rate of residents is significantly lower than for clients living in the community, despite higher overall dependency and frailty.

**Table 7.2 Mortality at Seward Lodge (April 1988-April 1990)**

| | | Residents | Day attenders |
|---|---|---|---|
| N | | 21 | 29 |
| Chrichton | ave | 19.71 | 13.86 |
| Royal | SD | 5.09 | 7.47 |
| Deaths | | 5 (23.8%) | 17 (58.6%) |

Interviews with staff at Seward Lodge point to a number of possible reasons for the higher mortality rate amongst day attenders:

i. People living in the community are more at risk from accidents. These may be fatal in themselves or may contribute to the person dying eventually.

ii. People living in the community may be living in conditions of neglect.

iii. Staff are in close contact with full-time residents and can notice symptoms and have illnesses treated at an early stage.

iv. High quality, full-time care may mean that residents survive illnesses and the effects of accidents.

The 'flu epidemic of the winter 1989/90 is seen to have had an effect on mortality at Seward Lodge. Twelve of the recorded 17 deaths in the sample of day attenders occurred in the six-month period September 1989 to February 1990. The same period saw two of the five recorded deaths amongst permanent residents.

Conclusion

Despite the limitations on the analysis, the results suggest that the sort of care environment provided by the experimental homes can increase longevity of EMI clients. Further research is required to provide a more comprehensive and sophisticated analysis of the effects of different care contexts on mortality.

This conclusion raises some intensely ethical issues. Should the extension of life for people with dementia be seen in positive or negative terms? Can residential environments be too "protective" of their clients? Do the people who live longer also benefit from good quality of life? These are questions that demand considerable thought on the part of policy-makers and service managers, not least for the possible financial implications increasing the chances of survival amongst this client group.

## PSYCHOLOGICAL WELL-BEING AND QUALITY OF LIFE

The great problem in the present research is that the normal measures of psychological well-being, such as morale scales or life satisfaction ratings could not be used with the mentally imparied clients in the experimental homes. The observation study included indicators of negative affect, in terms of observable outcomes of states-of-mind: irritation; sadness; anxiety. Data on these are available for Seward Lodge, Redcourt, and a long-stay psychogeriatric ward, but were not included in the original design for Highgrove House.

The prevalence of negative affect is summarised in Table 7.3. The figures show the percentage of daytime observations of residents that were classified as "negative affect". These figures can be taken as the proportion of residents' time that is occupied by being sad, irritated or anxious. Overall, the frequency is very low, ranging from 2.8% of all observations of clients for anxiety within Seward Lodge down to 0.2% of observations for sadness and irritation within Redcourt. There are also clear variations between the various units, with Seward Lodge having relatively high levels and Redcourt having low levels. Variations between units may be a result of various factors. For example, the use of medication to change residents' state of mind could be significant, although all the units operate a minimum medication regime. Another factor may be the "flattened effect" that is often associated with highly institutionalised regimes.

**Table 7.3 State of Mind of Residents**

| | Seward Lodge | Redcourt | Ward |
|---|---|---|---|
| Sadness | 1.4% | 0.2% | 1.8% |
| Irritation | 2.0% | 0.2% | 1.8% |
| Anxiety | 2.8% | 0.5% | 0.3% |

Some individuals also accounted for a considerable proportion of the overall figures. The variation between the level of negative affect between Seward Lodge and psychogeriatric ward has some points of interest. Both observation studies were undertaken by the same observer at about the same time, which would tend to reduce the chance of observer error. The clear variation between Seward Lodge and the comparison unit is in respect to levels of anxiety, while levels of sadness and irritaion are similar. An examination of the data indicates that sadness and irritation tend to be related to specific individuals and that the prevalence may depend more on client factors, such as personality or psychiatric condition, as opposed to factors related to the care context. Levels of sadness and irritability would thus depend on the mix of individuals within the institution. However, levels of anxiety within Seward Lodge are not simply related to specific individuals. The level of observed anxiety varies through the day and according to type of resident. The highest levels are recorded in mid-afternoon and indeed a third of all observations of anxiety were taken in the hour 14.30-15.30. This coincides with the arrival of the ambulances to take the day attenders home. Day attenders tend to become anxious prior to the arrival of the ambulances and the actual process of leaving is a source of agitation, occuring specifically in the reception area at the front of the building. Anxiety levels for the residents is fairly constant throughout the day, although a higher level was observed in the morning.

Another approach to assessment of the psychological well-being of clients that was utilised during the evaluation was through qualitative interviews with keyworkers and relatives and through the secondary analysis of client case notes. The qualitative data were content analysed (Krippendorf, 1980) with particular attention paid to the changes that occurred in the residents. The key question was whether the care that clients were receiving really "made a difference"? Although the data indicate considerable individual differences, in overall terms there appears to have been a progressive deterioration in respect to:

physical condition
self-care
mental functioning
participation
communication

Conversely, where positive changes have been perceived in residents, these have generally been in respect to:

anxiety/restlessness/agitation
cooperation
aggression
family relationships
emotional well-being

Anxiety, agitation and restlessness were often perceived to be important aspects of residents behaviour after admission. However, over time this appears to have changed for many of them as they become more calm and settled as they get used to the new environment. However, a distinction should be made between agitation or anxiety that has a specific cause and that which is associated with particular individuals.

Cooperation was often a problem both with residents with behavioural problems and those who were misunderstood the physical care provided by staff. Overall, these problems appear to diminish over time and staff talk about specific residents being "less resistive", "more amenable", "easier to manage". But is this a positive change? Some of the interviews with senior staff suggested that being "strong-minded" or "cantankerous" was an expression of independence and individuality. Alternatively, increased compliance may reflect increased passivity and "induced dependency".

Aggression was encountered in a number of residents and for many of those at Highgrove it was a major reason for referral as other institutions were unable to cope. Eight of the Highgrove residents were identified as showing aggressive behaviour, ranging from hitting out to verbal abuse. This has generally declined over time for a number of reasons. Firstly, medication was used in two cases. However, aggressiveness can be ameliorated in other ways. With increasing familiarity with residents, it is possible to recognise specific causes and intervene appropriately. One can also suggest that as residents become more familiar with each other and staff, the problem of territoriality may diminish.

Family relations between residents and their relatives is an important issue. Often carers feel guilty that they can no longer cope. They may feel uncomfortable when they come to visit. the strain of caring may have previously resulted in acrimony and bad feeling. In general resident-family relationships can be improved and sustained through active encouragement and counselling. Keyworkers often play an important role in this, through

understanding the family history and the individuals concerned.

Emotional well-being may perhaps represent the most significant aspect of the individual's quality of life. Particularly at Highgrove and to a lesser extent at Seward Lodge, residents' emotional states were seen to improve over time. They seem to be more assertive, more alert and responsive, friendlier, happier and more emotionally expressive. One of the underlying themes relates to residents showing their "true selves". A resident may begin to show more emotion, whether this is being more affectionate, happy or sad. These changes may be due to several factors. Some clients had previously been on high levels of medication to control agitation or aggressiveness. The "flatness" associated with these residents was no longer evident in a minimum medication environment. Residents may also become more familiar with the place and people that consitute their "home".

Conclusion

It is important to emphasise that the overall prevalence of negative affect was very low in all the units covered in the study. Of course, the absence of negative affect does not necessarily mean that clients enjoy positive well-being.

Qualitative data, however, did suggest a high level of well-being within the homes. Moreover, certain individuals were seen as benefitting from admission into residential care.

A specific note should be made about Highgrove where it should be remembered that admission criteria emphasised management problems. The qualitative data indicate that the overall level of change or "improvement" in Highgrove residents' psychological well-being after admission was particularly marked. However, there were differences between residents with fewer positive changes being recorded amongst those residents who were regarded as less demanding. For those with behavioural and psychological problems, care took on a much more positive and rehabilitative nature, with noticeable improvements in well-being.

Following-on from this last point, problems or deficiencies in mental functioning, confusion and self-help are often overlaid by problems of behaviour, agitation and anxiety. If these problems can be ameliorated then there is a likelyhood that improvements in orientation, communication and self-help will be achieved. This in turn may contribute to the individual's overall well-being, for example through feelings of acievement, or better empathy with others.

The key issue is that, in terms of quality of life and psychological well-being, some people benefit more than others from the specialist care that is being offered. This needs to be borne in mind when targetting limited resources for care of the elderly mentally ill.

**DEPENDENCY**

The common view of people suffering from irreversible organic brain disease is one of increasing dependency and progressive deterioration, particularly in respect to mental functioning and the ability to look after oneself. The question addressed in this section is whether the care provided within the homely homes had any impact on the common pattern of deterioration?

This section examines the change over time of residents in the homely homes in respect to dependency. The standard measure of dependency used here is the Chrichton Royal scale (Appendix 1), which covers aspects of physical and mental capabilities, cooperation and restlessness, and the ability to perform basic tasks of self-care, such as washing, eating, dressing and toiletting.

## Highgrove House

Table 7.4 points to some interesting changes amongst Highgrove residents after admission and shows that significant improvements in terms of dependency can be achieved. Figure 7.1 summarises the Crichton Royal assessments for the Highgrove residents in terms of five dimensions: physical; mental; social; self-help. It should be pointed out that summing the scores on individual items is a fairly crude measure of overall dependency. However, this does afford a rough indication of the main trends.

**Table 7.4**

HIGHGROVE DEPENDENCY:

CHRICHTON ROYAL MODAL VALUES OVER 36 MONTHS

| | Months | | | | | | |
|---|---|---|---|---|---|---|---|
| | ADM | +6 | +12 | +18 | +24 | +30 | +36 |
| 1 Mobility | 0 | 1 | 0 | 0 | 0 | 3 | 1 |
| 2 Memory | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| 3 Orient. | 4 | 2 | 3 | 3 | 3 | 4 | 4 |
| 4 Commum. | 3 | 2 | 1 | 1 | 1 | 3 | 2/3 |
| 5 Co-op. | 3 | 1/2/3 | 1 | 1 | 1 | 2 | 2 |
| 6 Restless | 3 | 2 | 1 | 1 | 1 | 0 | 0/1 |
| 7 Dressing | 4 | 1 | 3 | 3 | 3 | 4 | 3 |
| 8 Feeding | 0 | 0 | 0 | 1 | 1 | 1 | 1 |
| 9 Bathing | 3 | 1 | 2 | 3 | 3/4 | 4 | 3/4 |
| 10 Incont. | 2/3/4 | 0 | 2 | 0/3 | 4 | 3 | 4 |

(ADM refers to point of admission of residents)

Physical dependency: Overall, there was a slight deterioration. On admission most people were fully ambulent, which has slightly declined, although residents are still usually independent.

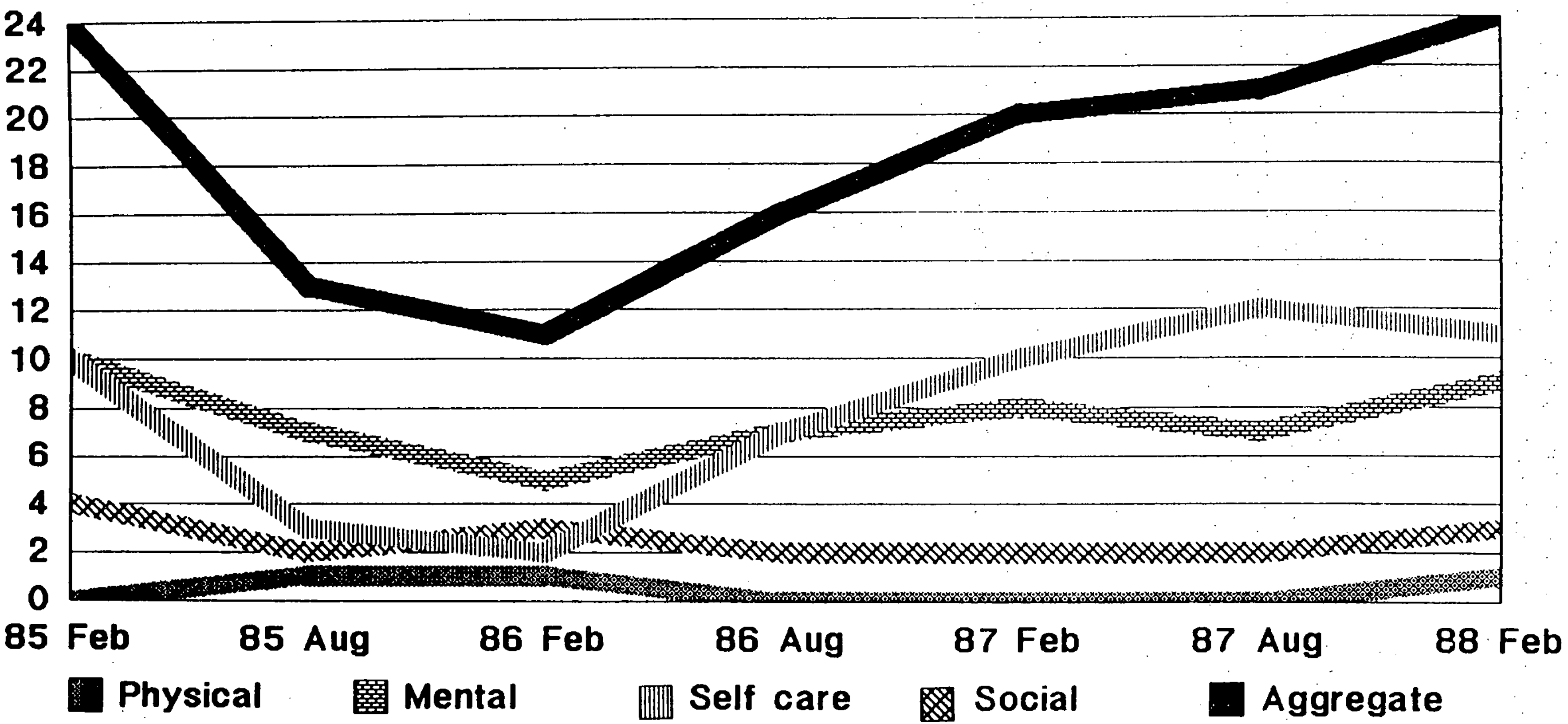



Figure 7.1

Mental functioning: On admission, residents scored very poorly. Initially, this improved markedly, but subsequently deteriorated to previous levels. This pattern is mainly due to better levels of orientation and improved communication, while memory functioning showed a much more stable profile.

Social/behavioural problems: The overall pattern shows slightly higher scores over the study period. Cooperation seems to have declined over time to a level where the majority of residents were classified as requiring frequent persuasion in order to get them to do things. Moreover, five residents were classified as being completely resistive. This pattern is reversed in the case of restlessness, where previously very active people had become much less restless. This change is attributed to a number of factors: keeping these people occupied; improved toiletting programmes; small homely groups; progressive physical deterioration.

Self-care: On admission, most residents were typically unable, or unwilling, to dress or bathe themselves and double incontinence was very prevalent. All these improved markedly after admission, but have since declined to previous levels.

Overall change: The overall pattern is clear. On admission to Highgrove the person would show a high degree of dependency as measured by the Chrichton Royal scale. This would show marked improvement after admission in respect to orientation and self-help, followed by a progressive deterioration to previous levels.

Individual differences: Out of 16 permanent residents at Highgrove, 12 showed an overall improvement over time, one showed no consistent pattern, while the remaining three showed consistent decline over the study period. Within the first group there was a wide range in terms of level of impairment, with rates of change also varying between individuals. However, the general pattern is highly consistent.

Factors behind observed pattern: The pattern of improvement after admission, followed by gradual deterioration is very significant. Reliability tests on the scaling procedure indicated that error was not likely to be a significant factor, although there is a possibility that the data exaggerates the rate of change over time. Discussion with senior staff at Highgrove suggests a number of contributing factors. Firstly, many of the residents had been receiving high doses of behaviour controllingdrugs, which may have contributed to their confusion. This in turn may have decreased their capacity for self-help. The minimal use of drugs at Highgrove may have helped to improve mental functioning and self-help. Also, the care regime at highgrove was geared towards the individuals' needs and problems. Individually-centred care may contribute towards the maximising of residents' potential. Anxiety is also a problem that can contribute to confusion. A homely atmosphere and the alleviation of anxiety through appropriate intervention may be a factor here.

Redcourt

Table 7.5 summarises residents progress over the two years from the opening of Redcourt. The dramatic improvement after admission seen at Highgrove is not found at Redcourt. The overall pattern is one of gradual deterioration particularly in respect to mobility and feeding. On admission residents typically had poor levels of memory functioning, orientation and self-help. Mobility, communication and feeding were less impaired, but

these deteriorated at varying rates accounting for the overall change in dependency.

The non-improvement after admission may be a function of the type of residents admitted to Redcourt. The admission criteria at Highgrove elicited people with behavioural and personality disorders that were amenable to rehabilitation. This selectivity was not a part of admission criteria at Redcourt and the potential for improvement of dependency would not be as great.

**Table 7.5**

REDCOURT DEPENDENCY:

CHRICHTON ROYAL MODAL VALUES OVER 24 MONTHS

| | Months | | | | |
|---|---|---|---|---|---|
| | ADM | +6 | +12 | +18 | +24 |
| 1 Mobility | 0 | 0 | 0/4 | 1/4 | 2 |
| 2 Memory | 3 | 3 | 3 | 3 | 3 |
| 3 Orient. | 3 | 4 | 4 | 4 | 4 |
| 4 Commun. | 2 | 4 | 4 | 3 | 4 |
| 5 Co-op. | 1/3 | 1 | 1 | 1 | 1 |
| 6 Restless | 0 | 1 | 1 | 1 | 1 |
| 7 Dressing | 4 | 4 | 4 | 4 | 4 |
| 8 Feeding | 0 | 1 | 1 | 1 | 4 |
| 9 Bathing | 4 | 4 | 4 | 4 | 4 |
| 10 Incont. | 4 | 4 | 4 | 4 | 4 |

The only profile that is contrary to the overall pattern is in respect to communication, which appeared to improve after several months where the modal score indicated minimum communication ability. This change is not due to measurement error as it was corroborated by two independent raters. This may reflect improved rapport between carer and resident, leading to improved communication rather than any specific change in the communication capability of the resident.

Individual differences: The overall pattern does hide some variation between residents. Of the twenty-two people included in the study, the biggest group of twelve people did show the general pattern of gradual deterioration. However, four people showed relatively little change over the two years and this was not related to their initial level of impairment. Although mental functioning tended to decline marginally, self-help abilities were retained. A further group of six people did show improvement over time, specifically in respect to restlessness and cooperation. This may be related to increased

familiarity with Redcourt over time and a more trusting relationship with carers. One man did show the Highgrove pattern. On admission he was highly impaired in respect to mental functioning, social problems and self-help. This has gradually improved over time to very low levels of impairment on all these dimensions.

Seward Lodge

As with Redcourt, the overall pattern of change amongst Seward Lodge residents does not exhibit the same U-shaped curve of improvement followed by deterioration curve that was found at Highgrove (Table 6). On admission, residents would typically have poor levels of orientation and memory functioning, but be relatively unimpaired in all other respects. Certainly Seward Lodge residents showed much lower levels of overall dependency on admission than either Highgrove or Redcourt. There was a fairly rapid deterioration in respect to dressing and bathing and a more gradual decline in terms of communication abilities and incontinence. Over an eighteen month period the level of dependency amongst residents was comparable to level found at Redcourt and at Highgrove after the initial period of improvement.

**Table 7.6**

SEWARD LODGE DEPENDENCY:

CHRICHTON ROYAL MODAL VALUES OVER 18 MONTHS

| | Months | | | |
|---|---|---|---|---|
| | ADM | +6 | +12 | +18 |
| 1 Mobility | 0 | 0 | 0 | 0 + |
| 2 Memory | 3 | 3 | 3 | 3 |
| 3 Orient. | 3 | 3 | 4 | 4 |
| 4 Commun. | 0 | 0/2 | 0123 | 4 |
| 5 Co-op. | 012 | 1 | 0 | 1 |
| 6 Restless | 1 | 1 | 0 | 0/2 |
| 7 Dressing | 1 | 4 | 4 | 4 |
| 8 Feeding | 0 | 0 | 0/1 | 0 |
| 9 Bathing | 2 | 4 | 4 | 4 |
| 10 Incont. | 0 | 1 | 1 | 4 |

Individual differences: Two-thirds of the 23 residents recorded during the study either showed gradual overall deterioration or no significant change. Another five people showed no consistent pattern. No resident showed consistent improvement, although the typical Highgrove pattern was found in three cases. However, it is not possible to point

to any contributory factor behind this. Again, the selection criteria for residents would not allow much scope for rehabilitation.

Differences between residents and day attenders: Seward Lodge has been able to maintain a core of people within the community for a considerable amount of time. Fourteen of the day attenders (28%) had been clients of Seward Lodge for over 12 months, of which seven (14%) had been supported for 18 months. However, there has been a considerable turnover of clients, with thirty-five having come and gone in a two year period. Twenty-four of these had been supported for less than six months. Of the leavers, twenty-five had either died or had deteriorated physically and had been admitted to hospital care. Three people had been admitted to residential care and seven people seven people could not be traced.

An analysis of dependency of stayers and leavers shows no overall difference in terms of level of dependency at the time of admission or in terms of change in dependency over time. It is therefore not possible to predict who is going to be supported succesfully from measures of dependency. It is clear that a large proportion of day attenders will be dead or have become physically frail within a few months of starting at Seward Lodge. This is compared with a very low mortality rate amongst permanent residents. This issue is explored in more detail in the section on mortality. Both groups show a deterioration in terms of mental functioning. However, over this time residents' level of self-help declined markedly, while the level for day attenders remained relatively stable.

Respite care: During the study a number of staff observed that holiday residents became more confused during the period of admission. Quantitative evidence is not available to support this claim. However, discussion with staff at Seward Lodge and with providers of respite care in other places does indicate that temporary admission does have an effect on clients. In two cases at Seward Lodge, orientation long-term memory, verbal communication and self-help all appeared to deteriorate from a fairly high level of functioning. This may be related to increased anxiety and the disruption of patterns of daily living. There appears to be very little research on the effects of respite care on the elderly mentally ill and it is certainly an issue that deserves further attention.

Institutionalisation: The dependency study of Clients at Seward Lodge points to the effect of "induced dependency" after admission to permanent residential care. Deterioration in self-help after admission is quite sharp and there are differences between residents and day attenders in terms of changes in self-help. Inter-correlation between all the items on the Chrichton Royal Schedule for all the units indicates that there is no significant relationship between cognitive functioning and self-help. Again, this may indicate the phenomena of induced, rather than "inherent" dependency.

## Conclusions

The analysis of dependency in the three experimental units leads to the following conclusions:

i. The assumed pattern of gradual deterioration associated with EMI clients is found in the experimental homes. However, this overall pattern can hide considerable individual differences and individual profiles indicate that this deterioration is not simple either in terms of rate or nature of change.

ii. Significant improvements are possible with people whose problems are primarily psychological or behavioural, rather than dementia per se. Depression and anxiety can be manifested in terms of high dependency. This has implications for targetting resources for maximum benefit and for more active approaches to treatment. It should not be assumed that high dependency is inevitable and adequate assessment and appropriate care can have significant results.

iii. Deterioration in self-help is not an inevitable change. There is no evidence here to suggest that changes in the level of self-help are directly related to changes in mental functioning. The problem of induced dependency may be endemic in residential care settings.

## OPINIONS OF RELATIVES

A key component in the evaluation of a service is the consumer viewpoint. Unfortunately, the elderly, mentally frail clients of the experimental units were unable to provide meaningful feedback and attention is given in this section to the opinions of relatives and informal carers. Relatives' opinions are pertinent on two counts. Firstly they act as advocates of the residents and day attenders. Secondly, informal carers are themselves beneficiaries of the service in that the task is no longer a viable option. This section provides data from qualitative interviews with principle informal carers and from a questionnaire survey. Data is presented for Highgrove and Seward Lodge. Redcourt has not been included as the original residents had been long-stay mental hospital patients for a considerable time prior to admission, often resulting in disengagement between patient and relative.

### Who is the carer?

The large majority of carers were female and the largest single group were daughters (ranging from 60% at Highgrove to 43% at Seward Lodge). This is a very common pattern and reflects structures in society that channel responsibility for informal care to this group. The second largest group were spouses, most of whom are themselves elderly. There are exceptions to the general pattern. For example, carers in the Seward Lodge sample included a son-in-law and a nephew. In terms of supporting the carers it is necessary to give particular attention to these individuals as they may have specific needs or problems.

### Attitudes towards care prior to admission

The survey of relatives of clients of Seward Lodge included questions about levels of staisfaction with other services in the locality. This is an important issue, given the realtively low provision of specialist services in East Hertfordshire. The majority of relatives were happy with the services they had been receiving prior to admission. The large proportion of clients were living in the community and the major

source of contact with health and welfare services were through GPs, Social Workers and CPNs. Day centres and relief care in psychiatric wards were also mentioned. A third of respondents said they were dissatisfied, reflecting the traditional neglect of the EMI client group. The relative absence of services in the locale was a problem. However, the apparent lack of interest and understanding on the part of health professionals, notably GPs, made this doubly frustrating.

## Levels of carers' involvement

The large proportion of carers said that they had been closely involved in the day to day care of their EMI relative. The nature of this involvement ranged from providing company to constant care and attention. The level of personal involvement was related to the dependency of the elderly individual. A third of the respondents said that they "did everything" for their relative or had to provide care around the clock.

Given the demanding nature of caring, it is hardly surprising that two-thirds of respondents said that there lives had been severely affected by their involvement with their EMI relative. There is a profound effect on the individual carer due to the constant worry, physical exhaustion and mental and emotional stress. The inability to "see an end" to the problem can be demoralising. Caring often affects the whole lives of the people involved, by disrupting family relationships, restricting social life and work opportunities.

Some people can cope with the demands of caring better than others. It is important that professional carers should not make judgements about what informal carers should be able and willing to do. Community support needs to be geared to the specific needs of the specific caring situation.

## Level of satisfaction with the homely homes

Respondents were overwhelmingly positive about the experimental homes, with about 90% saying they were very satisfied with the care given to their relative and the remainder saying they were satisfied. This response was expected as carers may be grateful for any help they receive or may be wary of making criticisms. However, the spontaneous comments made by carers provide a clear indication of a very high level of satisfaction. Typically:

"I have peace of mind that .... is in good hands and is being fed, bathed and cared for by staff with patience and understanding."

"The staff are wonderful and really care and the place is ideal ... I don't think you could improve on anything there; it is perfection itself."

The significant issues are the caring attitude of staff, the perceived high quality of care and the high quality of the physical environment. Respondents clearly saw the homely home as a step forward for their elderly relative and not simply a place for relieving the burden of care. Indeed some people felt that their EMI relative had directly benefited, either physically or emotionally, from admission.

Advantage for carer

The care provided by the homes should ideally alleviate the problems expresses earlier. The major areas of benefit to carers are:

i) peace of mind/relief from constant worry

ii) time freed to do other things other than continuous caring: neglected household chores; social life; work

iii) Knowledge that the relative is being well cared-for, thus alleviating the sense of guilt.

Benefits to the elderly mentally ill person

Respondents were asked to describe the main benefits of care to their EMI relative. A large number of people mentioned the quality of care: "good standard of care"; "caring attitude of staff"; the provision of functional care.

For day attenders at Seward Lodge the main benefits were perceived to be social reflecting the unremitting boredom and isolation that is usually the lot of the elderly mentally ill living in the community. Seward Lodge offers a change of scene, trips out and the company of others. Unlike the domestic environment, the building also affords freedom to walk around to relieve boredom and get exercise.

For residents at Highgrove, the emphasis was on their improved emotional well-being. Respondents frequently mentioned that their relative was happier, more contented and peaceful. This emphasis reflects the behavioural and emotional problems that were the criteria for admission to Highgrove. The comments of relatives suggest that Highgrove has had success in ameliorating these problems.

Criticisms of the Homes

Respondents were asked to point out any disadvantages for their elderly relative and any disadvantages for them personally. In general there were very few criticisms made by relatives.

At Seward Lodge, the major perceived problem related to the ambulance transport of day attenders. The inflexibility of the daily transport can be a difficulty. Some people have to get up too early in order to be ready and the inability to keep to a strict pick-up time can cause agitation, because of the waiting. A number of respondents felt that the staff situation at Seward Lodge was not ideal, in that they were understaffed and that some lacked experience. A number of elderly respondents mentioned that there were problems of getting to Seward Lodge to visit residents. At a more emotional level, some people mentioned feelings of loss because their spouse had become a permanent resident. Another issue is that some respondents felt uncomfortable when visiting, because they did not know what was expected of them or how to act. It is not always clear whether a relative should help with tasks of caring, or whether this is seen as "interesting".

Criticisms of Highgrove were fairly specific. One respondent was aggrieved at having to pay for residential care (unlike the other Homely Homes). One person would have liked a single room for their relative, rather than having to share. Another person felt that the location of Highgrove prohibited their relative going out.

## CONCLUSION

The evaluation of the three experimental homes allows a number of general conclusions to be made about residential care for the elderly mentally ill:

A positive approach to care: The research indicated that improvements in the psychological well-being of residents were achieved. Moreover, the experience in Highgrove House also indicated that it is possible to achieve improvements (albeit temporary) with some clients in respect to cognitive functioning and self-care. Thus, care of the elderly mentally ill should be seen in much more positive terms than has generally been the case within the caring professions.

Who benefits? The improvements outlined above were not observed in all clients. In particular, it is those people who had psychological, behavioural or psychiatric disorders as well as cognitive impairment who appeared to benefit most from the sort of care provided by the three homes. In view of this, it may be appropriate to target specialist resources at these people in order to maximise benefits.

Dependency and "demandingness": No direct relationship was found between dependency (as measured by standard instruments on physical condition, mental functioning and self-care) and the way staff resources were distributed amongst residents. For example, the frailest and most dependent residents do not necessarily consume the most care. This has implications for the way residential care is funded, as resources should reflect the actual needs of clients.

Maximising "positive care": The extra resources available within the experimental homes were largely channelled into routine care, such as resident hygiene, dressing and feeding. The relative failure to deliver "positive", life-enhancing care in line with extra resources is difficult to explain. However, the indications are that this is not due to the substitution of untrained for trained staff, but rather related to other issues such as the difficulty in sustaining positive activities with this client group. The research showed that the use of activity organisers or occupational therapy aides did result in higher levels of positive care. With clients with dementia, a care model which includes a considerable amount of task assignment stands a much greater chance of providing high levels of positive care than one which relies on personalized care alone.

Staffing issues: There is no evidence that the use of largely unqualified care staff to provide direct care resulted in any detriment to residents. Both Highgrove and Seward Lodge devolved responsibility for individual client care to unqualified staff. Unqualified staff were designated as keyworkers with responsibility for the development and implementation of client care plans. There is no research evidence to suggest that clients of the experimental homes were disadvantaged by this. However, "unqualified" does not mean "untrained" and considerable emphasis has to be placed on management support, in-service training of unqualified staff, quality assurance procedures and staff recruitment policy. Although based on a social services model of care with no direct nursing input, Highgrove was able to cope with residents with behavioural problems who would normally have been admitted to long-stay psychiatric or nursing care.

The physical environment: Although a common objective was to provide a "homely" living environment, residential accommodation based on communal living is invariably "unhomelike". Long corridors, offices and large

communal lounges were features that are not found in truly domestic environments. Individual bedrooms were used very infrequently by residents. Many residents were unable to find their own rooms, while the design of Redcourt and Seward Lodge did not encourage residents to use their own rooms. Architects and planners need to collaborate much more with care professionals and researchers during the dsign stage.

Longevity: Although the research data only allows tentative conclusions about survival, all three schemes had low death rates. Moreover, at Seward Lodge there was much higher death rate for day attenders compared with residents The indication is that the protective and specialist residential environments afforded by the homes promote the longevity of residents. This raises two issues. Firstly, from an ethical point of view, is the promotion of longevity amongst people with progressive cognitive impairment something that should be seen in positive or negative terms? Secondly, from a financial perspective, if residents live longer then the care that is being provided is effectively increasing demand, with obvious resource implications.

## REFERENCES


Beaumont, J. and A.J. Sixsmith (1984) "Elderly Severely mentally Infirm (ESMI) units in Lancashire: an assessment of resource allocation over space". In M. Clarke (ed) Planning and Analysis in Health Care Systems. London: Pion.

Booth, T. (1985) Home Truths. Aldershot: Gower.

Copeland J.R.M (1984) "Organisation of services for the elderly mentally ill". In Kay and Burrows (eds) Handbook of Studies on Psychiatry and Old Age. Elsevier Science Publishers.

Copeland, J.R.M., C. Crosby and J. Stilwell (1986) "District Experimental Care Schemes for Elderly Menatlly Ill People: Research Review and Prospectus". University of Liverpool, Department of Psychiatry and Institute of Human Ageing.

Copeland, J.R.M., M.E. Dewey, N. Wood, R. Searle, A. Davidson and C. McWilliam (1987) "Range of mental illness among the elderly in the community", British Journal of Psychiatry, 150, 815-823.

Crosby, C. (1985) "Homely Care District Experimental Schemes: Research Protocol and Schedule of Research Procedures". University of Liverpool, Department of Psychiatry and Institute of Human Ageing.

Crosby, C. (1986) "A study of disability and dependency grades in four different units caring for elderly mentally ill people". Department of Psychiatry, University of Liverpool.

De Zoysa, A. and G. Blessed (1984) "The place of the specialist home for the elderly mentally infirm in the care of mentally disturbed old people". Age and Ageing, 13, 218-223.

Gurland, B.J., J.R.M. Copeland, M.J. Kellaher, J. Kuriansky, L. Sharpe and L. Dean (1983) The Mind and Mood of Aging. New York: Haworth Press.

R. Harrison, N. Savla and K. Kafetz (1990) "Dementia, depression and physical disability in a London Borough", Age and Ageing, 19, 97-103.

Ineichen, B (1987) "Measuring the rising tide: how many dementia cases will there be by 2001"? British Journal of Psychiatry, 150, 193-200.

Krippendorf J. (1980) Content Analysis. Beverly Hills: Sage

Pattie, A. and C. Gilleard (1978) Manual of the Clifton Assessment Procedures for the Elderly.

Qureshi, H. and A. Walker (1989) The Caring Relationship. Basingstoke: Macmillan.

Robinson, J., T. Thompson, P. Emmons and M. Graff (1984) "Towards and Architectural Definition of Normalization". School of Architecture, University of Minnesota.

Sixsmith, A.J. (1988) "Locating mental health facilities: a case study". In C. Smith and J. Giggs (eds) Location and Stigma. London: Unwin Hyman.

Sixsmith, A.J. (1990) "Proposal for Research into Respite Provision for Elderly People and their Carers". University of Liverpool, Institute of Human Ageing.

Wilkin, D. and D. Jolley (1979) "Behavioural Problems Among Old People in Geriatric Wards, Psychogeriatric Wards and Residential Homes 1976-1978. University Hospital of South Manchester Psychogeriatric Unit, Research Report No 1.

## APPENDIX 1. MODIFIED CHRICHTON ROYAL BEHAVIOURAL RATING SCALE

| Item | Score | Description |
|---|---|---|
| Mobility | 0 | Fully ambulant, including stairs |
| | 1 | Usually independent |
| | 2 | Walks with supervision |
| | 3 | Walks with aide or under careful supervision |
| | 4 | Bedfast or chairfast |
| Memory | 0 | Complete |
| | 1 | Occasionally forgetful |
| | 2 | Short-term loss |
| | 3 | Short and long-term loss |
| Orientation | 0 | Complete |
| | 1 | Oriented in home, identifies people |
| | 2 | Misidentifies but can find way about |
| | 3 | Cannot find way about |
| | 4 | Completely lost |
| Communication | 0 | Always clear and retains information |
| | 1 | Can indicate needs, deal with simple directions and information |
| | 2 | Cannot understand simple verbal directions OR cannot indicate needs |
| | 3 | Cannot understand simple verbal directions AND cannot indicate needs |
| | 4 | No effective contact |
| Co-operation | 0 | Actively cooperative |
| | 1 | Passively cooperative or occasionally uncooperative |
| | 2 | Requires frequent persuasion |
| | 3 | Rejects assistance shows independent ill-directed activity |
| | 4 | Completely resistive or withdrawn |
| Restlessness | 0 | None |
| | 1 | Intermittent |
| | 2 | Persistent by day OR by night |
| | 3 | Persistent by day and by night |
| | 4 | Constant |
| Dressing | 0 | Correct |
| | 1 | Imperfect but adequate |
| | 2 | Adequate with minimum supervision |
| | 3 | Needs continual supervision |
| | 4 | Unable to dress OR retain clothing |
| Feeding | 0 | Correct |
| | 1 | Adequate with minimum supervision |
| | 2 | Needs continual supervision |
| | 3 | Requires feeding |
| Bathing | 0 | Requires no assistance |
| | 1 | Minimum supervision with bathing |
| | 2 | Close supervision with bathing |
| | 3 | Needs continual supervision |
| | 4 | Requires washing and bathing |

| Continence | | |
|---|---|---|
| | 0 | Full control |
| | 1 | Occasional accidents |
| | 2 | Continent by day with toiletting |
| | 3 | Urinary incontinence despite toiletting |
| | 4 | Frequent double incontinence |