Fred Miller (Third Floor)

Morning and afternoon sessions
Morning workshops
Making Mealtimes Matter
Background

Poor management of dysphagia and nutrition can be catastrophic to a person’s health and has huge financial implications to the NHS. **Two major causes of hospital admission are compromised nutrition and hydration.**

As a provider of community Speech and Language Therapy (SLT) and Dietetic Services, we want to use this **joint expertise** to provide training to care home staff to provide enjoyable meals to residents whose medical presentation and cognitive impairment prevents them from making food choices and experiencing enjoyable mealtimes.

Improving staff competence in managing swallowing problems and the provision of appropriate hydration and nutrition will improve residents’ **general health, wellbeing and quality of life**, reducing chest infections and weight loss and fewer dysphagia related hospital admissions.

“People need to have good nutrition for some of the drug regimes they are on. If you get nutrition right you give people a much better life.”

Martin Green, chief executive of Care England
Key learning of providing training to homes

• It was essential to get ‘buy in’ from management at each nursing home. We carried out a session 3 months before training started to take them through some practicals and explain why we were providing the course.

• We asked homes to include a manager on the training day – managers have the influence and authority to make changes that other staff may not have.

• A mix of staff was key to getting a wide reach into the staff pool.

• The approach of the training itself was based on practical sessions to break up the day and cement learning.
Our Approach:

Two sessions consisting of a day of training were provided for each nursing home. The sessions were interactive workshops including:

- Understanding the normal swallow
- Understanding a disordered swallow
- Fluid consistencies – how to thicken a drink
- Food consistencies – which foods are suitable for each diet
- Meal times – how to feed someone safely
- Fluid Fortification – how to make a fortified drink
- Meal planning – fortification of a menu
- Guessing the calories and protein of foods
- Taste testing supplements
- Preparing powdered supplements
- Calculating a patient’s risk of malnutrition without weighing them
- MUST training

Carers will be taken through the mealtime experience with 10 key items to remember:

- Positioning
- Alertness
- Food & fluid consistency
- Oral hygiene
- Environment
- Pace
- Amount
- Equipment
- Level of assistance
- Communication
Collaborating across services
why did we do it?

• Combined knowledge and skills from both SLT and Dietetics
• Resources have been produced which are more comprehensive and are kept with the homes - can be reproduced quickly and easily online
• Cross-learning between the specialities for clinicians involved
• Reduced inappropriate referrals into both services
• **Two sessions** to ensure we get as many nursing home staff in attendance as possible – as we all know their schedules are hectic
## The Benefits

<table>
<thead>
<tr>
<th>Patients</th>
<th>Care home</th>
<th>NHS</th>
</tr>
</thead>
</table>
| • Improving patients:  
  - Mealtime experience  
  - Nutritional status  
• Reducing the risk of:  
  - Choking episodes  
  - Unintentional weight loss  
  - Chest infections  
  - Pressure sores  
  - Falls  
• Reducing family anxieties around their relatives nutritional status.  
| • Improving staff confidence of:  
  - Using the MUST nutritional screening tool  
  - Referring to SLT and dietetics  
  - Managing swallowing problems in residents  
  - Providing safe meals in line with SLT recommendations  
• Improving team work and communication amongst staff in regards meal times.  
• Reducing waste (food)  
• Better record keeping and therefore better compliance with CQC requirements.  
• Recognition from CCG and award for biggest improvements seen  
| • Savings ££££  
• Reducing the number of:  
  - Supplements prescribed  
  - Hospital admissions  
  - Inappropriate referrals to SLT and dietetics  
  - Prescriptions for antibiotics  
|
Where we are now – The training programme delivery will finish in November

December to March – Final data collection from the nursing homes around admissions and other key data followed by a final evaluation and sharing of results
Some Examples from the course...

The staff are shown how to make fortified drinks and it will be advised that all care home residents with a MUST score 1 or more (at risk of malnutrition) be offered 2 home-made fortified milk drinks daily. Please see the following two slides.
Homemade fortified drinks

Moderate and High risk patients i.e. MUST of 1 or more - Suggest 2 homemade fortified drinks daily.

“Food First” milkshake
Fortified milky coffee
Fortified hot chocolate
Fortified malted drink
Fortified cup a soup
Fortified liquor drink
Fortified yoghurt drink
Fortified banana drink
Fortified pineapple drink
Fortified milk
Practical on thickening fluids
How did staff find the course?

1. I enjoyed the training
   - Strongly disagree: 1%
   - Disagree: 1%
   - Partially disagree: 5%
   - Partially agree: 25%
   - Agree: 68%
   - Strongly agree: 1%

2. I found the training informative
   - Strongly disagree: 1%
   - Disagree: 1%
   - Partially disagree: 3%
   - Partially agree: 14%
   - Agree: 81%
   - Strongly agree: 1%

3. I can use the info provided in my working life
   - Strongly disagree: 1%
   - Disagree: 1%
   - Partially disagree: 1%
   - Partially agree: 16%
   - Agree: 78%
   - Strongly agree: 2%

4. I would recommend this training to others
   - Strongly disagree: 1%
   - Disagree: 1%
   - Partially disagree: 3%
   - Partially agree: 11%
   - Agree: 84%
   - Strongly agree: 2%

5. I found the activities useful
   - Strongly disagree: 1%
   - Disagree: 1%
   - Partially disagree: 3%
   - Partially agree: 18%
   - Agree: 77%
   - Strongly agree: 1%
We asked 4 key questions to rate staff confidence levels:

How confident are you:

A/ Feeding someone with swallowing problems
B/ Understanding and being able to thicken residents fluids in accordance to the 3 stages recommended by SLT
C/ Managing someone who is choking
D/ Completing the MUST tool on one of your residents
Improvement in confidence levels by home

[Bar chart showing improvement in confidence levels for different homes, with specific percentages for each home.]

Bromley Healthcare
better together
Sundridge Court – How they found the course

Carol Marsh – the manager at Sundridge Court sent us a list of all the changes the team had made since their training which were too many to list, although it has made a huge difference and even contributed to the success of their recent CQC visit

- There has been a noticeable change with residents feeding themselves
- Awareness throughout the team and knowledge of special diets
- They are now fortifying all meals

Would I recommend this training?

“Yes I would and I would also like to have the opportunity to offer it to more of my staff in the future.”
Thank you for your time...
here is some of the feedback

“I found the training very useful and crucial in my life of working. I feel at present I can be influential in empowering junior staff with the knowledge gained.”

“Thank you it has given us a project to work towards within the home. Great to work in partnership with this team.”

“highly informative and practical.”

“I would like this course to be repeated in one years time to keep carers and nurses updated and to maintain good practice.”

“I have learnt a lot and will apply it to my work daily.”

“most enjoyable course I've attended for a long time.”
The Behaviour and Communication Support Service (BACSS)

Luminata Cupsa - Deputy Manager
Ashmead Care Centre
Dr Ally Tomlins - Highly Specialist Clinical Psychologist
Katie Whitewood - Clinical Lead BACSS
Our population:

- Population 65+ = 24,204
- Approx 2031 people with Dementia in 2013
- 17 Care Homes (nursing and residential)
- Approx 1100 care beds
- Up to 90% of people with Dementia will have BPSD
About us:

• Piloted in Oct 2013

• Piloted in 4 care homes in Wandsworth until June 2014

• Now fully substantiated across the borough (10 care homes)

• Encouraging psychosocial management of BPSD
Commissioner/ Service Outcomes:

• To prevent inappropriate hospital admissions for people residing in Wandsworth Care Homes who are challenging staffs’ abilities to provide them with person centred care.

• To prevent inappropriate care home moves for residents in Wandsworth Care Homes on account of behaviour that is challenging and to maintain people in the current environment.

• To support the appropriate use and reductions of antipsychotic medication for residents of Wandsworth Care Homes, who are challenging for staff to care for.

• To reduce the frequency and severity of the challenging behaviour from pre to post intervention, as measured by the Challenging Behaviour Scale.

• To reduce 1:1 support required through Continuing Healthcare where appropriate.

• To improve the Quality of Life for people living with dementia.
Our ethos:

• Systemic approach to managing and understanding behaviour that challenges.

• Understanding behaviour that challenges in the context of an unmet need.

• Understanding behaviour in the context of someone's life history and life experiences.

• Promotion of good practice in understanding and managing behaviour that challenges.

• Non-pharmacological approaches as first line treatment for mild/moderate challenging behaviour.

• Medication for only severe challenging behaviour and/or when other approaches have been tried or risk is significant.
Care pathway:

Weeks 1-4 Assessment phase
- Meet with care staff.
- Meet with family, complete life history.
- Meet with other professionals involved.
- Review medication.
- Rule out physical causes e.g. pain.
- Complete observations.
- Care staff to complete behaviour monitoring forms.

Weeks 4-6 Formulation and care planning phase
- Formulation session with care home staff.
- Discuss behaviours in the context of life history and life experiences.
- Think together about psychosocial interventions that may help.
- Care plan interventions.
Care pathway continued:

**Weeks 6-12**
**Supporting and evaluating phase**
- Support care staff to trial interventions.
- Model best practice.
- Evaluate and update care plan.

**Weeks 13**
**Discharge**
- Complete outcome measures.
- Write discharge summary and send to all involved in residents care.
- Discharge from service if appropriate.
Common reasons for referral to BACSS

- Physical aggression (care staff/other residents)
- Verbal aggression (care staff/other residents)
- Shouting/calling out
- Refusing support with personal care tasks
- Sexualised behaviour
- Difficulty engaging resident
- Not sleeping at night
Interventions used

• Identifying the resident’s current unmet needs and helping staff to meet these needs through person-centred care.

• Specific interventions:
  • Communication techniques (VERA Framework)
  • Simulated presence
  • Doll therapy
  • Pet therapy
  • Life story/ reminiscence
  • Therapeutic story telling
  • Sensory therapy
  • Outdoor activity
  • Occupational therapy
Audit 2015-2016

- 120 were referred to the BACS team.
- Challenging behaviour scale (CBS) completed with staff at initial assessment and discharge.
  - CBS measures the frequency and severity of a range of challenging behaviours.
  - Possible CBS scores range from 0 to 400. Higher scores indicate a greater frequency and severity of challenging behaviours.
Audit 2015-2016

• At initial assessment:
  • 93 residents were audited
  • Average CBS score: 87.56

• At discharge:
  • No score available for 24 residents (15 passed away before discharge, 9 data missing)
  • Of the remaining 69 residents, CBS score was reduced for 66 of them (96%), and increased for 3 (4%).
  • Average CBS score (discharge): 30.40
Thank you for listening....
Any questions?
Afternoon workshops
Using research to create a RADIQL approach to Dementia Care with Reminiscence Arts
• My profession & role
• What is Age Exchange is
• Reminiscence Arts Practice
• RADIQL Research Programme
• The Future
Age Exchange has worked with older people for over 30 years to combat loneliness & improve their quality of life by giving them opportunities to express themselves in the present through verbal and non-verbal ways:

- multi art form, heritage and performance arts projects
- intergenerational projects- Schools and archives
- International- Poland, Belgium, France, Germany, US
- exhibitions
- publications
- documentary film

Café, library, theatre, Reminiscence Centre
- 90 volunteers aged 14-94
- Outreach- care, community, drop-in and domiciliary settings, schools museums

Recognized internationally as being the leading practitioners, consultants and source of information about reminiscence.
Reminiscence Arts Practitioners are trained and experienced in different areas of the arts and have attained at least graduate level of arts/design, with some also obtaining post-graduate, health, social care related and art therapy qualifications.

RAPS co-facilitate their reminiscence arts sessions

e.g. a dance practitioner with a visual artist or a musician with a heritage expert

Age Exchange is unusual in the way it offers dementia training and places two project workers together to run sessions. This allows for a dynamic and wide ranging experience and for project workers to support individuals in the groups who may need a little more attention.
Reminiscence Art is the introduction of different art-forms into reminiscence practice.

It is a social, participatory, creative intervention, co-facilitated by two professional and trained arts practitioners.

Guided by a set of principles building on a non-linear narrative communicated either through speech, drama, literature, song, making art/craft, listening to or making music, handling objects/artifacts, using props, dancing to music or embodying memory through distinct movements.

Uses a variety of techniques enabling participants to connect with a long-term memory and express themselves through the medium of a creative activity in the present.

It differs from reminiscence as it is not about ‘just about looking into the past’, that has traditionally been seen as a linear narrative mixed with oral history.
Context

• There are currently 800,000 people with dementia in the UK
• There are over 17,000 younger people with dementia in the UK
• There are over 11,500 people with dementia from black and minority ethnic groups in the UK
• Studies report that many older people living in UK care homes are experiencing increasing social isolation and lack of engagement (NICE, 2014)
RADIQL™

Reminiscence Arts and Dementia Care: Impact on Quality of Life

Innovative Research Shaping the Future of Dementia Care
Aims

• Provide quantitative evidence and cost benefit analysis for the effectiveness of Reminiscence Arts (RA) on the wellbeing of people with dementia

• Define, develop an intervention and pedagogic framework for care staff based on evidence

• To analyse how the environment and culture of care was affected by the RADIQIL programme
Objectives

Guy’s & St Thomas’ Charity £620,00 grant to:
• Support innovation in health

Independently researched by Royal Holloway University London, St Georges NHS Trust and Simetrica
• Comparative, time based study with a control group
• 6 treatment and 6 control sites
• Cost Benefit Analysis
• Data collected through DCM
• An innovative, evidenced intervention & pedagogic framework that measurably improves quality of life
Numbers
• 12 care homes in Lambeth & Southwark
• Lambeth and Southwark healthy Ageing cafés

Ran
• 288 group sessions in care homes with 77 people
• 55 group sessions in the 2 cafes with 120 people
• 200 1-1 sessions in care homes with 30 people
• 1 carers group for relatives with 8 relatives
• 2 public seminars with 170 people

Trained
• 22 artists, professional practitioners in dementia and reminiscence arts
• 3, 1-day staff training sessions with 45 care staff
• 6 be-spoke training workshops in care homes with 60 staff
• 16 staff mentoring sessions with 8 staff
• Around 20 staff involved in experiential training within 336 sessions
• Around 150 staff trained
Findings

• Improved Mood and Engagement by 42%
• Improved Positive Behaviours by 25%
• Statistically significant and steady increase week on week
• After 3 months there was still improvement showing
• For every pound invested there is a 14% return in health benefits at the upper bound DoH estimate
• Produced health benefits that more than offset the costs of the programme indicating that it is a worthwhile investment in terms of health improvements
• Costs £1269 pp (including intensive staff training)
At baseline, the ‘control’ homes had higher QoL than the ‘intervention’ homes. During sessions, positive behaviour increased and peaked after sessions, QoL appeared to drop below the start, perhaps because of fatigue and return to routine. After sessions, there was a sustained positive effect for 30 minutes. Every 3 weeks, the behaviour was more positive than at the start of the previous session. After the sessions had finished, the behaviour returned almost to baseline.

After the sessions had finished, the behaviour returned almost to baseline.
• The unique intervention is a fusion of reminiscence and arts, with a relationship-centred approach as key underlying mechanism

• In contrast to existing therapeutic or creative interventions, it supports people to be understood, and also to communicate in their own way, enabling creative expression in the modality that best suits the person, such as music, art, drama, words, song, craft, handling objects, movement and dance

• It seeks to harness knowledge about a person from staff, relatives and the person’s narrative or embodied movements, focusing sessions, chats and interaction that utilizes this knowledge
Mechanisms

• Engagement with their past activities and agency within the present moment and setting

• Sensory materials, music and stories that formed part of the person’s past identity

• Handling/ vintage artifacts, natural materials and objects, sounds from outside; birdsong, rivers, trees rustling, gravel crunching, photographs of remembered locations.
Relationship- centred and empathetic
Staff Feedback

- The creative intervention improved mood, positive affect, reduced aggression and impacted on staff own wellbeing:

  “Monday was my happy day!” (when the session was running)

- RADIQL helps people eat, drink and sleep better

- Martin is swearing less, will sing and shout but in a less aggressive ‘get off me kind of way’- doesn’t seem so angry or lost any more

- Jane had to be sectioned and restrained a lot, now she sits and joins in, claps, smiles and is calm
Workforce Training

- Aligns to National Service delivery Frameworks e.g. Care Certificate
  Work in a person-centered way, communication, equality and diversity

- 1 day Meaningful engagement for formal sessions and principles for daily care (12th October, SW11)

- 2 day participatory class room, experiential & coaching course

- Be-spoke courses suited to needs

- Experiential and coached

- Strengths based and a continuum of self, team and patient care
This study is enabling Age Exchange to develop a high quality, evidence-based conceptual and pedagogic framework for social care workforce, art practitioners and a structured therapeutic intervention of delivery in care homes and day-care.
Conclusion

Evidenced work is providing opportunities to attract funding and commissions e.g.:

• Big Lottery funded project creative day care
• Tenders to CCG’s and major funders e.g. Southwark
• Arts Council/ Wandsworth Council/ D’Oyly Carte/ Trinity Laban Conservatoire of Dance developing a performance, film and original sound track ‘bringing to Life’ the academic practice to create a public facing product
David Savill
Artistic Director
www.age-exchange.org.uk


Reducing Loneliness in Care Homes through Trained Volunteers
Learning and Outcomes:

1. Loneliness in care home residents
2. Role of volunteers in reducing loneliness
3. Practicalities and considerations
4. Wider benefits brought by volunteers
Care home residents are twice as likely to be severely lonely compared to the community dwelling elderly (Victor 2012)
The effects of loneliness

Low mood
Reduced wellbeing
Hopelessness
Increased risk of dementia
Depression
Hypertension
Poor sleep
Increased mortality
LONELY

NOT LONELY

DEMENTIA
LOSS
CHANGE
MENTAL HEALTH PROBLEMS
UNMET EXPECTATIONS

MET EXPECTATIONS
NEARBY FAMILY & FRIENDS
RESILIENCE
INVolVEMENT IN ACTIVITY
COMMUNITY
VOLUNTEERS
FRIENDLY STAFF

EMBRACING AGE
Later life in all its fullness
A flexible, personalised approach, with a wide range of interventions that meets individuals’ needs
Care Home Friends

Over 1000 hours of quality time spent with care home residents in the last 18 months.
Lil Patrick (Third Floor)

Morning and afternoon sessions
Morning workshops
Family Perceptions of Care Audit

Jean Levy/Fran Conway/Julie Kinley

October 2016
## Background

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage of deaths occurring in nursing care homes</th>
</tr>
</thead>
</table>
| 2007-08  | 57%  
[n=324 deaths across 19 NHs] |  
| 2008-09  | 67%  
[n=989 deaths across 52 NHs] |  
| 2009-10  | 72%  
[n=1071 deaths across 53 NHs] |  
| 2010-11  | 76%  
[n=1375 deaths across 71 NHs] |  
| 2011-12  | 78%  
[n=1351 deaths across 71 NHs] |  
| 2012-13  | 77%  
[n = 1375 deaths across 72NHs] |  
| 2013-14  | 76%  
[n = 1232 deaths across 72NHs] |  

Purpose of the audit

To use the views of bereaved family members of residents who die in local care homes to learn about and develop the end of life care provided by those homes
Family Perception of Care Scale

- Validated tool specific to care homes
- Used in previous team research
- 25 items / 4 domains
  - Resident Care
  - Family Support
  - Communication
  - “Rooming”
  - Short Likert style questions over three pages
Outcomes

• Family members share their experiences

• The care home staff can reflect on and learn from the family members’ views

• The care home improve the quality of end of life care provision and able to evidence this

• Care home staff gain confidence and skills in end of life care
Structure of audit

- Documentation kept re family member
- Family Perception of Care Questionnaire
- Analysis / Feedback / Reflection
- Plan for improvement where required
Audit Process

Step One
Care homes record data about next of kin + relevant information

Step Two
Care homes send out questionnaires three months after resident death

Step Three
Completed questionnaires are returned to St Christopher's Care Home Project Team for analysis

Step Four
St Christopher's provides feedback about all questionnaires to area meetings

Step Five
St Christopher's works with individual care homes to produce action plans for improvement
Follow up

• Care Home Project Team feeds back results to managers every six months

• Care home managers share results with staff

• Staff work together to make changes, organise training, give support and celebrate good feedback.

• Evidence of improvements in the quality of care for GSFCH accreditation or Steps to Success portfolio
Items achieving most agreement were (%)

- Privacy: Year 1 88%, Year 2 87%
- Staff friendly: Year 1 93%, Year 2 86%
- Dignity: Year 1 88%, Year 2 84%
- Overall satisfied: Year 1 84%, Year 2 80%
- Kept informed: Year 1 78%, Year 2 80%
Items with least agreement / wider spread of responses were

- The **GP had time to discuss issues with me** whether face to face or on the telephone

- Chaplaincy services were at hand for my family member

- **Others** included rites and rituals, information about end of life and GP visits
Ranking for importance re excellent end of life care

- Dignity (44%)
- Pain Eased (32%)
- Staff sensitive (24%)
Success

“I have tried to vary the scoring away from the perfect seven but I can only add that my mother was treated with respect, dignity and had all physical and spiritual needs attended to by the team at xxx. . . . .”
Family Perceptions of Care Audit
with thanks to the Burdett Trust for Nursing and Croydon CCG

Jean Levy/Fran Conway/Julie Kinley

October 2016
Democratic Participation in Care homes
Everyone deserves a voice

Madeline Cooper-Ueki
October 2016
About NDTi

National Development Team for Inclusion (NDTi)

- Not-for-profit organisation, concerned with promoting inclusion and equality for people who risk exclusion and who need support to lead a full life.

- Particular interest in issues around age, disability, mental health and children and young people.

www.ndti.org.uk
madeline.cooper-ueki@ndti.org.uk
What is democratic participation?

- Voting
- Community activism
- Engagement with local politicians and councillors
- **Giving people a voice**
  
  *and all citizens have a right to this, whatever their age, capacity or support needs*

- Do people in care get involved??

---

“Democracy is when the indigent, and not the men of property, are the rulers.”

--- Aristotle, 350 BC
The project…

- With the Order of St John’s Care trust
- Developing **Voting Champions** in the run up to the general election
  - Learning about rights and why people vote or take part in other ways
  - Learning about how to have conversations about what’s important to people
  - Understanding capacity
  - Thinking about activities to stimulate debate
- Voting champions included staff, families, residents and volunteers
- Immediate and 6-month evaluation carried out
The project… some context

- Across wide geography - four counties
- Care homes for people with range of needs including those with very complex health needs
- Traditional staffing set up in some, and newer support worker roles in others
- Organisation wide communication programme
- Many staff disengaged from democratic participation and voting themselves - most said they had been “sent there” on the first workshop
Why do you vote...or not?

- Family tradition
- Because someone fought for your right to (e.g., women’s vote)
- Because you think it makes a difference... Or doesn’t
- Charismatic person or politician
- Someone is saying something about what is important to you
- Because changes are promised which will make your life better
Creative activities to get people involved

- Conversations 1:1 or small groups about what’s important to people and what that might mean for their own choices
- Inviting candidates to visit - Residents prepared questions
- Going to, or holding hustings
- Joining local community groups to bring about change
- Using voting for group home decisions
- Politics from then until now - reminiscence focus
A celebration
What people told us…

“People are now engaged with politicians, some residents are even speaking more.”

“We found that the residents liked to meet the local MP and following on from that we invite him to all of our events”
Benefits

- Its Your Choice! A chance to enact your views and have your own personal say
- Everyone can be involved
- People who were often invisible were seen by politicians and local community
- Many became more involved in their local communities
“As a result residents now hold their own resident meetings (historically chaired by the HM). They have elected a secretary, a chair person and vice secretary and chair person. The HM receives the minutes and actions accordingly.”

“I feel it has made them more positive in the way they approach residents. As each resident is individual & needed different explanations, to enable them to understand.”
What people told us…

“By using the information gained at training days and my understanding of capacity to talk these doubters into realising everyone has the right to vote.”

“Yes the team have far more involved conversations with the residents, not just talk about the weather.”

“People in general appear more open minded as to how older people still have rights, thoughts and feelings.”
Benefits

- It encouraged the homes to open their doors
- Increased the ways in which people were given choice and control day to day

- Many people are more involved in home and personal decisions
- **Changed conversations**
- **Changed Attitudes!**

people  lives  communities
For further info:
Madeline.cooper-ueki@ndti.org.uk
Embedding person-centred approaches
http://www.communitycare.co.uk/2015/05/01/bringing-democracy-care-home-can-improve-quality-care/

Everyone Deserves a Voice
https://www.journalofdementiacare.co.uk/news,everyone-deserves-a-voice_63.htm
Useful information

From the Electoral Commission:

- Legal incapacity to vote only applies to people such as detained offenders.

- A lack of mental capacity is not a legal incapacity to vote: persons who meet the other registration qualifications are eligible for registration regardless of their mental capacity or lack thereof.

- A mental health condition is not in itself a legal incapacity to vote. The electoral registration officer should assist if requested, those who are making an application or wish to find out more information about the electoral system.
Useful information

From the Alzheimer’s society

**Question:** Can a person with dementia vote in the UK general and local elections?

**Answer:** Yes, a person with dementia can vote regardless of their capacity.

- It is clearly stated in the Electoral Commission’s guidance that mental health conditions do not constitute a legal incapacity to vote, so a person would not be stopped from voting at the polling station.

- Guidelines also state that the decision as to whether and how to vote at an election must be made by the elector themselves, and not by a carer or a person making decisions on behalf of the elector.

**NB** this means that no Guardian or Lasting Power of Attorney relates to decisions about voting, and no voting decisions can be made in the person’s best interests.
Afternoon workshops
Southwark Nursing Home Service

An MDT Approach
A focus on The MDT approach

A view from
- Southwark CCG
- Link Consultant geriatrician
- Care home pharmacist
- Sternhall Lane Surgery
- Southwark Social Care
Since April 2014
3 nursing homes
272 beds

Multiple GPs to a nursing home.
Now one GP surgery looking after all 3

Monitored via KPIs/CQUINs
The Service so far

- 4 GPs, Consultant, Pharmacist
- Surgery linked computer in the home
- Regular ward rounds, routine and proactive care
- Medication review
- Care planning
- Coordinate my care
- A webpage: [http://sternhalllanesurgery.co.uk/nursing-homes/](http://sternhalllanesurgery.co.uk/nursing-homes/)
- Protocols and forms
- Audit
- Multidisciplinary team working
The MDT Model

Consultant in Older People’s Medicine
GP
Care Home Staff
Residents
Care Homes Support Team
Speech and Language Therapy
Tissue Viability Nurses
Mental health/Behavioural support
.............and more teams
Social Workers
Pharmacist
Specialist Palliative Care
Care Homes Intervention Team
Home Enteral Nutrition Team
Podiatry
.............and more teams

Monthly MDT
Southwark CCG
Matthew Griffiths
CCG Aims of the service

- **Quest for Quality (BGS, 2011)**
  - General Practice not sufficiently resourced to meet the needs of this complex group
  - GPs working in care homes feel unsupported
  - Working in partnership is critical to providing effective healthcare to support older people.

- **Aims**
  - Properly resourced primary care service
  - Coordination and multidisciplinary working
  - Integration through social care involvement
  - Senior medical input and support to GPs from consultant geriatrician sessions
  - Reduction in unplanned hospital use
A&E Attendances from Care Homes

New Model Implemented

Month of A&E Attendance

- Comparator
- Southwark Homes

A&E Attendances per 100 beds

2012/13, 2013/14, 2014/15, 2015/16
Care home pharmacist

Claire Tunstell
Medicines optimisation, not medicines supply

- Avoid unnecessary medicines
- Improve medicines safety
- Reduce medicines waste
- Reduce missed doses
- Monitor medicines
Main benefits

- Clinical pharmacy review of safety & quality of prescribing
- Medicine Reconciliation on transfer of care
- Trouble shooting medicines–related issues
- Medicines information
- Regular interaction with care home staff
- Policy development
- Reduced wastage
Kings College Hospital
Dr Jane Evans
Consultant in Clinical Gerontology

- **Joint Ward Rounds and Reviews**
  - Development of clear, realistic and logical management plans
  - The Frailty Syndrome and the impact on treatment, expectations and medication
  - Nutritional Care plans

- **Multidisciplinary Team (MDT) Meetings**
  - Coordination of the working of the MDT
  - Patient focussed and responsibilities allocated
  - Review of appropriateness of medications
  - Advance care planning and symptom control with appropriate support from Palliative Care specialists, as required

- **Individualised End of Life Care plans:**
  - Priorities of care for the dying person (ICARE)
The nursing home link worker role

- Scheduled and unscheduled reviews of nursing home residents
- Rotation of social workers to the link worker role, sharing learning within the team
- Attendance of monthly MDT meetings
- Joint assessments for NHS Continuing Healthcare
- Source of advice/support/information to staff in respect of all aspects of Adult social care
Positive contributions from social care

- A knowledge of a residents social history and often the circumstances surrounding their admission to the home
- Knowledge about family support and their views
- Advice about social care processes and legal aspects of placement
- Information sharing to aid other MDT members assessments
- Advice around safeguarding issues
- Improved communication with specific and generalised queries on residents.
How Social Care benefits

- Improved relationships with different teams
- An improved understanding of the role and functions of the different teams resulting in more appropriately directed referrals and queries.
- Improved communication with specific and generalised queries on residents.
- A greater understanding of health issues and medication and how they might impact on a resident's functioning as well as their family
Learning, going forward

- Challenges of maintaining effective communication within an MDT.
- NHS email/secure communication
- Reflection/significant events – engaging the homes
- Formalising, embedding and sharing protocols
- Taking audit forward e.g. Falls
- Formal evaluation – ?national (William Roberts) or local metrics
Any questions, feedback or suggestions are welcomed
The future of collaborative working across care and education providers enabling the delivery of bespoke, high quality higher apprenticeship programmes

Maaike Vandeweghe
Lead for Advancing Practice
Greenwich & Bexley Community Hospice
October 2016
Background

- South London Hospices Education Collaborative (SLHEC)
- *National End of Life Care Strategy* (DoH, 2008): workforce development, training and education a MAJOR theme and subsequent reports e.g. *Talent for Care and Widening Participation; it matters* (HEE, October 2014) and *The Shape of Caring Review* (HEE, March 2015)
- Lack of career development for Health Care Assistants
- Challenges around Registered Nurses (NHS AfC, Band 5) recruitment
- Previous piece of work in 2013 with *Skills for Health* in response to recommendations from the Francis Report (Cavendish, 2013) and *Cavendish Review* (Mid Staffordshire NHS Foundation Trust, 2013)
We were looking for...

- Higher Apprenticeship training and a vocational qualification which will support the delivery of **high quality care** to patients and their families, regardless of setting
- A programme which offers Health Care Assistants the opportunity to **progress** their career
- A commitment from employers to **invest** in Health Care Assistants’ training and education
- An opportunity to **redesign services** and create opportunities for Health Care Assistants
- A programme which will **address recruitment issues** and create opportunities to rethink how we deliver services
- Highly skilled and trained Health Care Assistants so **registered staff** can be **released** and supported to focus on specific areas
Development

- Funded by Health Education South London
- **Steering group** to support the development and management of the project
- Identifying relevant vocational programme through the support of City & Guilds
- **Working group** to shape the *curriculum* and ensure the proposed content was relevant and desirable for identified career opportunities and required skills
- Careful recruitment of appropriate and interested **partners**
- Ensuring **commitment** and support from all partners involved at all levels of the organisation
The Programme

• City & Guilds nationally accredited framework L5 Diploma for Assistant Practitioners in Healthcare
• Delivered by South London Hospices and Nightingale Hammerson Care Home, in collaboration with Croydon College
• Higher Apprenticeship funding available
• Transferable to all health care settings
• Cohort 1 March 2015
• Entry requirements
• Delivered over 2 years, 35 study days / year at Croydon College
• Knowledge and competency units based on the National Occupational Standards
L5 Diploma for Assistant Practitioners

- Mandatory units: 108 credits
- Option group B: 7/8 credits
- Option group A: 5 credits
Units included within the Qualification

- Human Biology
- Holistic assessment and physiological measurements
- Nutrition and Fluids
- Communication Skills
- Working in Partnership
- Managing quality
- Developing health and safety and risk management policies and procedures
- Principles and philosophy of health care
- Research
- Leading and managing a team within health care
Implementation

• Clearly defined roles and responsibilities amongst partners
• Careful recruitment of learners and support provided throughout the programme
• Robust support mechanisms in place for teachers and work-based assessors
• Regular steering and working group meetings to assess, monitor and promote successful implementation and to share workforce development opportunities and strategies
• Use of technology to communicate effectively with learners, teachers and assessors
• Recruitment of external evaluator
Outcomes

Individual level:

- Reviewing roles and responsibilities
- Skill mix reviews
- Development of relevant job descriptions
- Redesigning services
- Collaborative working

Strategic level:

- Reviewing roles and responsibilities
- Skill mix reviews
- Development of relevant job descriptions
- Redesigning services
- Collaborative working

It has been an amazing opportunity, it has opened so many doors and given somewhere for health care assistants to go in their careers.

At first I was unsure I was academically suited to the course but with time, support and passion I have overcome these barriers.

It has certainly positively impacted on my practice, I now feel confident to question practice at work.
Outcomes

Individual level:
I find academic work very hard, I didn’t like doing presentations but I am improving.

Hard to be able to complete portfolio work with assignments and homework, plus having to work full time.

Strategic level:
• Challenges with releasing staff
• Financial or strategic constraints
• Change management
• Collaborative working

I think the issue is that I am always on shifts so we are expected to do observations whilst being on shift which is difficult when you are allocated a number of patients.
Impact

• Professional and personal development
• Involvement with research and evidence based practice
• Driving change
• Increased knowledge, skills and confidence
• Developed leaders and managers
• Job opportunities
• Health Care Assistants focusing on career progression

-> knowledgeable, skilled and well supported staff delivering high quality end of life care
Future

• Continuation of collaborative working across the health care and education provider sector is the future if we want to influence training and education of the future workforce

• Work closely with partners to continue to develop workforce development strategies incl. job opportunities

• Continuation of the bespoke L5 Diploma for Assistant Practitioner programme and relevant other vocational programmes

• Publish article by December 2017

• Involvement with national initiatives and opportunities following on from Shape of Caring Review (HEE, March 2015) e.g. Nursing Associate Role pilot test sites (January 2017)
Any Questions?
References


Maaike Vandeweghe
Lead for Advancing Practice

020 8320 5781
0782 7892123
maaikevandeweghe@gbch.org.uk
education@gbch.org.uk

@maaik30be
Max Nasatyr (Third Floor)

Morning and afternoon sessions
Morning workshops
Southwark Nursing Home Service
An MDT Approach
A focus on The MDT approach

- A view from
  - Southwark CCG
  - Link Consultant geriatrician
  - Care home pharmacist
  - Sternhall Lane Surgery
  - Southwark Social Care
Background

- Since April 2014
- 3 nursing homes
- 272 beds
- Multiple GPs to a nursing home.
- Now one GP surgery looking after all 3
- Monitored via KPIs/CQUINs
The Service so far

- 4 GPs, Consultant, Pharmacist
- Surgery linked computer in the home
- Regular ward rounds, routine and proactive care
- Medication review
- Care planning
- Coordinate my care
- A webpage: [http://sternhalllanesurgery.co.uk/nursing-homes/](http://sternhalllanesurgery.co.uk/nursing-homes/)
- Protocols and forms
- Audit
- Multidisciplinary team working
The MDT Model

- Consultant in Older People’s Medicine
- GP
- Care Home Staff
- Residents
- Social Workers
- Pharmacist
- Care Homes Support Team
- Speech and Language Therapy
- Tissue Viability Nurses
- Mental health/Behavioural support
-………..and more teams
- Specialist Palliative Care
- Care Homes Intervention Team
- Home Enteral Nutrition Team
- Podiatry
-………..and more teams

Monthly MDT
Quest for Quality (BGS, 2011)
- General Practice not sufficiently resourced to meet the needs of this complex group
- GPs working in care homes feel unsupported
- Working in partnership is critical to providing effective healthcare to support older people.

Aims
- Properly resourced primary care service
- Coordination and multidisciplinary working
- Integration through social care involvement
- Senior medical input and support to GPs from consultant geriatrician sessions
- Reduction in unplanned hospital use
A&E Attendances from Care Homes

New Model Implemented

Comparator
Southwark Homes

Month of A&E Attendance

2012/13
2013/14
2014/15
2015/16
Care home pharmacist

Claire Tunstell
Medicines optimisation, not medicines supply

- Avoid unnecessary medicines
- Improve medicines safety
- Reduce medicines waste
- Monitor medicines
- Reduce missed doses
Main benefits

- Clinical pharmacy review of safety & quality of prescribing
- Medicine Reconciliation on transfer of care
- Trouble shooting medicines-related issues
- Medicines information
- Regular interaction with care home staff
- Policy development
- Reduced wastage
Consultant in Clinical Gerontology

- **Joint Ward Rounds and Reviews**
  - Development of clear, realistic and logical management plans
  - The Frailty Syndrome and the impact on treatment, expectations and medication
  - Nutritional Care plans

- **Multidisciplinary Team (MDT) Meetings**
  - Coordination of the working of the MDT
  - Patient focussed and responsibilities allocated
  - Review of appropriateness of medications
  - Advance care planning and symptom control with appropriate support from Palliative Care specialists, as required

- **Individualised End of Life Care plans:**
  - Priorities of care for the dying person (ICARE)
Southwark Social Care
Community Support Team
The nursing home link worker role

- Scheduled and unscheduled reviews of nursing home residents
- Rotation of social workers to the link worker role, sharing learning within the team
- Attendance of monthly MDT meetings
- Joint assessments for NHS Continuing Healthcare
- Source of advice/support/information to staff in respect of all aspects of Adult social care
Positive contributions from social care

- A knowledge of a residents social history and often the circumstances surrounding their admission to the home
- Knowledge about family support and their views
- Advice about social care processes and legal aspects of placement
- Information sharing to aid other MDT members assessments
- Advice around safeguarding issues
- Improved communication with specific and generalised queries on residents.
Improved relationships with different teams
An improved understanding of the role and functions of the different teams resulting in more appropriately directed referrals and queries.
Improved communication with specific and generalised queries on residents.
A greater understanding of health issues and medication and how they might impact on a residents functioning as well as their family.
Sternhall Lane Surgery

GP MDT Lead
Learning, going forward

- Challenges of maintaining effective communication within an MDT.
- NHS email/secure communication
- Reflection/significant events – engaging the homes
- Formalising, embedding and sharing protocols
- Taking audit forward e.g. Falls
- Formal evaluation – ?national (William Roberts) or local metrics
The future of collaborative working across care and education providers enabling the delivery of bespoke, high quality higher apprenticeship programmes

Maaike Vandeweghe
Lead for Advancing Practice

Greenwich & Bexley Community Hospice
October 2016
Background

- South London Hospices Education Collaborative (SLHEC)
- *National End of Life Care Strategy* (DoH, 2008): workforce development, training and education a MAJOR theme and subsequent reports e.g. *Talent for Care and Widening Participation; it matters* (HEE, October 2014) and *The Shape of Caring Review* (HEE, March 2015)
- Lack of career development for Health Care Assistants
- Challenges around Registered Nurses (NHS AfC, Band 5) recruitment
- Previous piece of work in 2013 with *Skills for Health* in response to recommendations from the Francis Report (Cavendish, 2013) and *Cavendish Review* (Mid Staffordshire NHS Foundation Trust, 2013)
We were looking for...

• Higher Apprenticeship training and a vocational qualification which will support the delivery of high quality care to patients and their families, regardless of setting

• A programme which offers Health Care Assistants the opportunity to progress their career

• A commitment from employers to invest in Health Care Assistants’ training and education

• An opportunity to redesign services and create opportunities for Health Care Assistants

• A programme which will address recruitment issues and create opportunities to rethink how we deliver services

• Highly skilled and trained Health Care Assistants so registered staff can be released and supported to focus on specific areas
Development

• Funded by Health Education South London
• **Steering group** to support the *development* and *management* of the project
• Identifying relevant vocational programme through the support of City & Guilds
• **Working group** to shape the *curriculum* and ensure the proposed content was relevant and desirable for identified career opportunities and required skills
• Careful recruitment of appropriate and interested **partners**
• Ensuring **commitment** and support from all partners involved at all levels of the organisation
The Programme

• City & Guilds nationally accredited framework L5 Diploma for Assistant Practitioners in Healthcare
• Delivered by South London Hospices and Nightingale Hammerson Care Home, in collaboration with Croydon College
• Higher Apprenticeship funding available
• Transferable to all health care settings
• Cohort 1 March 2015
• Entry requirements
• Delivered over 2 years, 35 study days / year at Croydon College
• Knowledge and competency units based on the National Occupational Standards
L5 Diploma for Assistant Practitioners

Mandatory units
108 credits

Option group B
7/8 credits

Option group A
5 credits
Units included within the Qualification

- Human Biology
- Holistic assessment and physiological measurements
- Nutrition and Fluids
- Communication Skills
- Working in Partnership
- Managing quality
- Developing health and safety and risk management policies and procedures
- Principles and philosophy of health care
- Research
- Leading and managing a team within health care
Implementation

• Clearly defined roles and responsibilities amongst partners
• Careful recruitment of learners and support provided throughout the programme
• Robust support mechanisms in place for teachers and work-based assessors
• Regular steering and working group meetings to assess, monitor and promote successful implementation and to share workforce development opportunities and strategies
• Use of technology to communicate effectively with learners, teachers and assessors
• Recruitment of external evaluator
Outcomes

Individual level:

- Reviewing roles and responsibilities
- Skill mix reviews
- Development of relevant job descriptions
- Redesigning services
- Collaborative working

Strategic level:

- Reviewing roles and responsibilities
- Skill mix reviews
- Development of relevant job descriptions
- Redesigning services
- Collaborative working

It has been an amazing opportunity, it has opened so many doors and given somewhere for health care assistants to go in their careers.

At first I was unsure I was academically suited to the course but with time, support and passion I have overcome these barriers.

It has certainly positively impacted on my practice, I now feel confident to question practice at work.
Outcomes

Individual level:

I find academic work very hard, I didn’t like doing presentations but I am improving.

Hard to be able to complete portfolio work with assignments and homework, plus having to work full time.

Strategic level:

• Challenges with releasing staff
• Financial or strategic constraints
• Change management
• Collaborative working

I think the issue is that I am always on shifts so we are expected to do observations whilst being on shift which is difficult when you are allocated a number of patients.
Impact

- Professional and personal **development**
- Involvement with research and evidence based practice
- Driving **change**
- Increased **knowledge, skills and confidence**
- Developed leaders and managers
- Job opportunities
- Health Care Assistants focusing on career progression
  
  -> knowledgeable, skilled and well supported staff delivering high quality end of life care
Future

• Continuation of collaborative working across the health care and education provider sector is the future if we want to influence training and education of the future workforce

• Work closely with partners to continue to develop workforce development strategies incl. job opportunities

• Continuation of the bespoke L5 Diploma for Assistant Practitioner programme and relevant other vocational programmes

• Publish article by December 2017

• Involvement with national initiatives and opportunities following on from Shape of Caring Review (HEE, March 2015) e.g. Nursing Associate Role pilot test sites (January 2017)
References


Maaike Vandeweghe
Lead for Advancing Practice

020 8320 5781
0782 7892123
maaikevandeweghe@gbch.org.uk
education@gbch.org.uk

@maaik30be
Any questions?
Afternoon workshops
Namaste

“To Honour the Spirit Within”
Contents

• What is Namaste Care?
• Key Elements
• Why I decided to introduce it
• Objectives
• Criteria for receiving Namaste Care
• How it is delivered
• Audit Process and Tools
• Case Study
• First Year Audit
• Communication
What is Namaste Care?

• It is a care programme originally developed in the US by social worker, Joyce Simard.
• It is person centred and provides a way of communicating and connecting with individuals including the use of intensive sensory stimulation.
• Person Centred Therapy recognises the importance of the individuals first, the disease second (Kitwood, 1998).
Namaste Care – Key Elements

- “Honouring the spirit within”
- The presence of others – “togetherness”
- Comfort and pain management
- Sensory stimulation: 5 senses
  - Sight, touch, taste, hearing, smell
- Life History – know about the person
- Meaningful Activity
- Staff Education
- Family Involvement
- Namaste is continuous and should flow seamlessly into end of life care
What do you see in this picture?
People With Dementia In Hospital Receive……..

- More inappropriate interventions
- Less symptom management
- Fewer referrals for specialist palliative care
- Less recognition of their spiritual needs
- Families are asked to make decisions in times of crisis

(Morrison & Siu 2000; Sampson et al 2006)
Quality of EoLC For People With Dementia

Studies in the UK and USA suggest those with end stage dementia in acute hospitals, psychiatric wards and nursing homes experience high levels of ‘suffering’, more than 60% ie the majority, receive sub-optimal end of life care.

Naomi Feil – ‘Validation Therapy’

- US Social Worker, Naomi Feil, first opened the door to a new way of caring for people with dementia with her ‘validation approach’.
- ‘Validation Therapy’ sees the essence of the person and finds a way to connect with them using knowledge of the person, touch and continuity.
- The basic principle is the concept of validation which communicates that the other person’s opinions are acknowledged, respected and heard and that they are being treated with genuine respect as a legitimate expression of their feelings, rather than marginalised or dismissed.
- Showing connection, compassion and care by entering their inner world and seeing through the dementia to the inner person.
- *You Tube: Gladys Wilson and Naomi Feil*
- These principles are also embodied within Namaste Care.
Why I decided to introduce Namaste Care

• Improve and better meet the needs of service users with end stage dementia
• Enable service users to remain within our care
• Improve the quality of life for those users who can often be marginalised
• Focus on individual users and their needs
Objectives of Namaste Care

- To improve the quality of life and sense of well being
- To decrease/eradicate UTIs
- To decrease/eliminate the use of anti psychotic medication
- To decrease/eliminate pain
Criteria for Receiving Namaste Care

- FAST – Functional Assessment Staging Test.
- It is usually service users who would be graded between 6d – 7e
- Namaste Care is not exclusive!
- Service users who do not meet this criteria are still welcomed to the room
F.A.S.T

- 6d Urinary incontinence
- 6e Faecal incontinence
- 7a Speech limited to about 6 words in an average day
- 7b Intelligible vocabulary limited to single word on average day
- 7c Cannot walk without assistance
- 7d Cannot sit up without assistance
- 7e Unable to smile
The Namaste Environment

• The room:
  – Warm, Inviting and Private with good use of calming colours
  – Muted lighting which encloses and draws users in
  – Pictures and objects that make sense to the users and can be used during tactile sessions
  – An awareness that sound creates atmosphere (a ‘Sense of Calm’ DVD)
How We Deliver Namaste Care

- The room is set up and lavender infuser, DVD and fire is put on
- Touch is used to welcome each service user to the Namaste room and they are greeted by name
- Placed in a comfortable lounge chair or pressure relieving recliner
- Pillows or towels are used to comfortably position
- A quilt or blanket maybe tucked around them for extra comfort and reassurance
- Assessed for pain / discomfort
How We Deliver Namaste Care – cont’d….

• Drinks and a treat of their choice are offered
• Carer starts with one user, for approximately 20 minutes, by which time, they are very relaxed. They then move onto the next user.

As appropriate:
• Wash hands/face, apply lotion, brush hair, shave
• Therapeutic touch – head, hands or foot massage, sensory apron, life-like dolls and animals
• Programme honed to the individuals interests and current state of mind. We may use photograph albums, books, DVDs etc.
Audit Process

- Audit Tool – PAINAD
- Audit Tool - QUALID
- UTIs - Medical Records
- Anti Psychotic Medication - MAR Charts
- Results Published in “American Journal of Alzheimer’s (October 2015) - Effects of Namaste Care: Pilot Study” (Beverley A. Manzar, CQSW, DSW, RMA and Ladislav Volicer, MD, PhD)
PAINAD
(Pain In Advanced Dementia)

• What is PAINAD? An observational pain assessment tool for those with advanced dementia. Developed as a tool for measuring pain in non communicative individuals.

• Devised by a group of clinicians - Warden, Hurley and Volicer.
QUALID
(Quality of Life in Late Stage Dementia)

• What is QUALID? An 11 item scale assessing the individual’s quality of life.
• Devised in 2000 by Weiner and colleagues (clinicians with extensive experience in dealing with people with dementia)
Case Study

- Trudy was a 85 year old service user who lived at Ebury Court since March 2007.
- Upon admission, she had a diagnosis of dementia but could express her wishes and choices, feed herself and perform some personal care with support. Medication controlled diabetic.
- Eight months after admission, in November 2007, she began to display signs of agitation which progressed to challenging behaviour. This was managed by the use of anti-psychotic medication – 10mg, OD.
- Chlorpromazine. She remained on this dose until 13.12.10 when it was increased to 25mg, OD.
- As her dementia progressed, she began to lose the ability to move around independently and the ability to communicate verbally in any meaningful way, became dependent on carers for all personal care and lost the ability to feed herself independently (could only feed herself if given finger food).
- She resisted any form of tactile interaction, did not like to be touched and any efforts to connect with her in this way were firmly rebuffed by her.
- Baseline QUALID = 38; PAINAD = 1.
Case Study - Results

• On 11\textsuperscript{th} December 2013, Trudy commenced the Namaste Care Programme. Chlorpromazine was prescribed at 25mg, OD.

• On 3\textsuperscript{rd} March 2014, her Chlorpromazine was reduced to 25mg every three days and on 4\textsuperscript{th} September 2014, this medication was stopped completely.

• When she first went into the Namaste Room, her PAINAD score was 1 and decreased to 0 at week 19. Her QUALID baseline score, ie the assessment made prior to commencing the programme, was 38 and remained at 38 at week 1.

\begin{align*}
\text{Wk 2} &= 33 & \text{Wk 3} &= 28 & \text{Wk 4} &= 26 & \text{Wk 5} &= 26 & \text{Wk 6} &= 25 \\
\text{Wk 7} &= 25 & \text{Wk 8} &= 22 & \text{Wk 9} &= 22 & \text{Wk 10} &= 22 & \text{Wk 11} &= 22 \\
\text{Wk 12} &= 22 & \text{Wk 13} &= 19 & \text{Wk 14} &= 19 & \text{Wk 15} &= 19 & \text{Wk 16} &= 19 \\
\text{Wk 17} &= 18 & \text{Wk 18} &= 17 & \text{Wk 19} &= 13 & \text{Wk 20} &= 13 & \text{Wk 21} &= 13 \\
\text{Wk 22} &= 12 & \text{Wk 23} \text{ – Wk 51} &= 11 & \text{Wk 52} &= 12^{*} \\
\end{align*}

* Trudy had a chest infection.
First Year Audit - Trudy
(December 2013 – November 2014)

- Commenced programme - 11.12.13
- Died – 22.03.16
- QUALID – commenced at 38, decreased to 11
- PAINAD – commenced at 1, decreased to 0
- UTI – none
- Anti Psychotic Medication – reduced on 03.03.14 and stopped on 05.09.14
Case Study - Summary

Why was Namaste Care effective for Trudy?

- She enjoyed the calm and peaceful environment and was visibly relaxed
- She benefitted from the continuity of the programme ie she attended daily for four hours
- She responded very positively to the 1-2-1 attention and the carers were able to utilise their knowledge of her and her interests to maximise their interaction
- She reacted positively to the music
- She was no longer involved in challenging situations
- She enjoyed tactile interaction and reached out for this herself
- She felt validated
- The powerful combination of continuous interaction, knowledge of the individual, a compassionate approach and the ‘power of the loving touch’ is highly effective.
Communication

• It is generally accepted that a huge proportion of all communication is non verbal*
• Essence of Namaste Care is to find a meaningful way to communicate with people who have dementia when words are no longer understood
• Tactile therapies
• Creating a sense of love, care, compassion, nurture and interest in the individual by using all five senses

* 55% body language, 38% tone of voice, 7% actual words spoken (Mehrabian & Wiener, 1967 and Mehrabian & Ferris, 1967).
What do you see in this picture?
“The Power of Loving Touch”
The Role of Occupational Therapy in the Mental Health Care Home Intervention Team

By Chris Lagadi & Linda Healy

Mental Health of Older Adults and Dementia
South London and Maudsley NHS Foundation Trust
Mental Health Care Home Intervention Teams (CHIT)

- Specialist mental health team offering interventions to support care staff meet the mental health needs of older adults in care homes with behaviour that challenges

- 3 teams across 4 boroughs within SLaM: Croydon, Lewisham, Lambeth & Southwark.

- Teams include clinical psychology, psychiatry, community psychiatric nurses, occupational therapy, pharmacy (in Lewisham). Teams led by clinical psychologist

- Behaviours that are challenging (Behavioural and Psychological Symptoms of Dementia) considered to be a communication of an unmet need (Cohen-Mansfield, 2000)

- Psychosocial, evidence based interventions alongside use of appropriate medication in line with SLaM care pathway and stepped care approach (British Psychological Society, 2013)

- Aim to prevent avoidable psychiatric admissions, prevent unnecessary or facilitate appropriate care setting moves
What is Occupational Therapy?

Enable people to achieve health, well being and life satisfaction through participation in occupation (College of Occupational Therapists)

"Occupation" refers to practical, purposeful and meaningful activities that allow people to live independently and have a sense of identity (self-care, work and leisure)

Wilcox (1998)
Why OT role in CHIT


Wellbeing of older people in care homes (NICE guidance, 2013)
- Participation in meaningful activities, including ADL’s
- Personal identity
- Recognition of mental health & physical conditions
- Recognition of impairment
- Physical problems

Dementia: support in health and social care (NICE guidance, 2010)
- Behavioural & Psychological Symptoms of dementia must receive comprehensive assessment
- Need to identify opportunities for clients to participate meaningfully in life within care homes to maintain wellbeing

Individualized interventions based on behaviour patterns may provide a more sensitive approach to the overall treatment needs of individuals with dementia...a combination of apathy and agitation is the most common phenomenon (Buettner & Fitzsimmons, 2006)
OT role in CHIT

• OT specific assessments: Functional assessment & strengths based (Volitional Questionnaire, Interest Checklist)

• Prioritising engagement in person centred, meaningful activities and evidence based interventions e.g. multisensory stimulation (NICE, 2006)

• Activity analysis & grading to optimise activity participation

• Falls assessment & prevention interventions

• Equipment: Signposting & advisory role for care home managers

• Providing other MDT members with consultation and advice
MHOAD Care pathway checklist

Behaviour and psychological symptoms of dementia (BPSD)

Step 1: Assessment of common physical and psychiatric causes

- Complete NPI to assess service user/carer behaviour & distress
- Complete physical health assessment:
  - Delirium or urine/other infections
  - Medication side effects
  - Constipation
  - Sleep sensory loss
- Pain assessment
- Cognitive assessment
- Depression assessment
- Psychosis assessment
- Assess risk to self/others
- Consider CPA

Has this been effective?

NO  Go to Step 2/3
YES  Discharge ~ 4 weeks

Unless behaviours very severe & high risk medication should not be initial treatment for BPSD

Step 2: Understanding the person in their environment

Assessment includes:
- Same as above +/-
- Behaviour records
- Life History
- History of psychosocial factors
- History of physical environmental factors
- Social context
- Occupation
- ADLs (use BADLS)
- Communication abilities of person
- Carer communication skills and style of interacting
- Biopsychosocial formulation

Interventions in care plan may include:
- Dementia awareness training for staff
- Develop staff communication skills
- Life history completion
- Use of memory/activity boxes
- Engagement in meaningful activity
- Environment changes
- Psychiatric Medication in line with MHOAD dementia care pathway

Has this been effective?

NO  Go to Step 3
YES  Discharge ~ 14 weeks

Step 3: High intensity and specialist interventions

Assessment can include:
- Same as above +/-
- Clinical Psychiatric Assessment
- Occupational Therapy Assessment
- Speech and language assessment
- Psychiatric review
- Biopsychosocial formulation

Interventions in care plan may include:
- As above plus eg
- Behaviour management programme
- Protocol Treatment eg TRA approach
- Validation
- Doo Therapy
- Reminiscence therapy
- Psychiatric Medication in line with MHOAD dementia care pathway
- Expert second opinion

Discharge Complete NPI
• 78 year old gentleman with Alzheimer’s disease, Nursing Home resident for 1 month

• Agitated, aggressive, restless behaviour requiring 1:1 care. Wandering with verbal and physical aggression particularly when prevented from going into others rooms and during personal care

• High risk of falls
Observation & formulation session – need for **meaningful and purposeful occupation**

Wandering – Exploring environment to understand and seek **safety and security**

Described spending his time ‘*getting from A to B*’ and ‘*seeing what’s around*’

Occupational identity: Carpenter by trade & ‘*handy man*’
Normal routine facilitated: Nightly window check

Room personalisation

Motivation to ‘do’ was facilitated with guided wandering utilising skills e.g. repair work needed

Visual cues & contrasting toilet seat

Activity scheduling

Language that values skills – ‘can you help me/have a look at...’

Validation: & re-direction meet his need to explore and ‘do’

Meaningful social interactions - a non-alcoholic malt drink replicating socialising at the Pub drinking Guinness

Exploratory, tactile activities:
- Item sorting (folding clothes/packing into drawers), wood sanding, painting, gentle chair based exercises, looking at a fishing book, building a stamp book, dismantling objects e.g. clocks

(Kielhofner, 2008)
Outcomes

• Shift in staff attitude and confidence – understood behaviour in context of his motivation for activity, his life story and need to ‘keep busy’

• Permanent staff used for 1:1 - consistency which enhanced implementation of care plan

• Therapeutic use of 1:1 was key in managing behaviour - structured, and opportunistic, meaningful activity

• Room personalisation – helped orientation & reduced wandering

**Neuropsychiatric Inventory assessment**

Initial assessment: Frequency x Severity score: **49**  Distress: **21**

Discharge: Frequency x Severity score: **23**  Distress: **8**
Challenges

• No access to equipment – funding issues

• Limited direct role in delivering interventions as advised in care plan

• Staff confidence and skills/day to day demands of care home
• OT care pathway specific to CHIT (with CAG lead and support)

• Networking locally and nationally

• Other CHIT developments: working more closely with GPs via MDTs, implementation of WHELD in Lewisham- key role of OT in supporting personalised social interaction intervention


South Bank room 1 (LG Floor)

Morning and afternoon sessions
Morning workshops
Better Together: An Integrated Approach to Enable Active Residents in Care Homes (ARCH)

Bernadette Kennedy
and
Dr Raymond Smith
Organic learning and application

https://www.youtube.com/watch?v=H0_yKBitO8M
ARCH aims

1. To **improve the health and quality of life** of resident’s (with dementia) in care homes through increasing their level of participation in **meaningful activity**.
ARCH aims

2. To **increase the confidence and skills of care home staff** to actively facilitate residents’ engagement in meaningful activity and to **reduce barriers** to resident’s wellbeing.
ARCH aims

3. To **identify environmental barriers** to activity and resident wellbeing in order to initiate actions to address these (org./physical/social).
ARCH aims

4. To create a culture of activity where residents are supported to engage in meaningful activity throughout the day and where activity is considered integral to care.
Occupational performance (or well-being) results from a ‘good fit’ between the three components (P-E-O).
Right place, right time, right people

- Involves three self-selected residential care homes from three different London boroughs catering for older people with or without dementia
- Intervention takes place over one year in each care home
- First four months are the ‘implementation phase’ and months five to 12 are the ‘consolidation phase’
Implementation overview

- **Getting to know you**
- **Staff training & actions from 'getting to know you' implementation plan**
- **Resident assessments & development of activity plans**
- **Implementation of residents' activity plans and consolidation of staff learning**
- **Hand over & continuation of programme**
Evaluation aims

• To evaluate whether the ARCH programme improves the activity levels and wellbeing of older people (65+) living in residential care homes

• Measure the effectiveness of ARCH (quantitative outcome measures)

• Assess the costs of the programme (through economic evaluation)

• Explore the acceptability of the programme (qualitative interviews)
Evaluation measures

Residents
- EQ-5D-5L (self rated quality of life)
- Semi-structured interviews
- Dementia Care Mapping

Family members
- Semi-structured interviews

Staff
- Pool Activity Level (PAL) -
- proxy EQ-5D-5L (quality of life for residents)
- Sense of competence in dementia care staff (SCIDS) scale
- Semi-structured interviews
Data collection

• Currently ongoing
• Baseline, 4 months and 12 months
• 35 residents at baseline
• 35 staff at baseline
• 18 family members at baseline
Data analysis (so far...)

• Analysis is ongoing
• Quantitative analysis of Dementia Care Mapping (DCM) with help of a statistician and health economists with the economic evaluation
• Qualitative baseline analysis completed using framework analysis (Ritchie & Spencer, 1994)
Themes from interviews with residents

- Feeling disconnected & restricted
- Disabling environment and loss of agency/lack of control over it
- Lack of stimulation (activities)
- Remembering an active past
- Active minds (the perceived positive impact of activity on the mind)
- Future hopes & personal goals
- Declining health
- Relationships with staff
When you’re just there by yourself, it can get boring, I sit there thinking what am I going to do, walk round, that’s the most I’ve ever done, and that’s not far. Sit down and then go back. R4

So sometimes you walk but sometimes they push you? Yeah. Most of the time in the morning because they have a certain time to finish. So they, so it suits them. R1

Can you tell me from your perspective what it’s like living here? Well, can’t really because [laughs] it’s not really living.
Resident’s signs of wellbeing
Thanks for listening

Any questions?

Email: bernadette.kennedy@stgeorges.nhs.uk
Twitter: @BernadetteKenh0

Lead clinician: Liezl.Anderson@stgeorges.nhs.uk

Email: R.J.Smith@sgul.kingston.ac.uk
Twitter: @_Raymond_Smith
DeAR GP
Dementia Assessment Referral to GP for Care and Nursing Homes

Aileen Jackson: Senior Project Manager

Health Innovation Network
Prime Minister’s challenge on dementia
Delivering major improvements in dementia care and research by 2015
Find Assess Investigate and refer

Commissioning for quality and innovation (CQUIN):
2013/14 guidance
February 2013
Identifying dementia in care homes

- 75% - 89% of Care home residents have dementia; many of these are undiagnosed.

(Lithgow, Jackson & Browne 01
http://ageing.oxfordjournals.org/content/43/4/562)
Don’t let care home residents slip through the dementia net

Dr Alistair Burns

National Clinical Director for Dementia, NHS England, December 2014
Why diagnose?

- Ability to care plan and case manage properly
- Better understanding of unmet need
- Facilitates ability to construct ‘formulation’ and fine tune care
- Facilitates staff to interpret signs, symptoms, behaviours
- Access post diagnostic support (eg. ‘Care Home Intervention Teams’)
- Reduced acute sector admissions; lower length of stay
- Human right
Method and Questions

• Focus groups in 4 care homes

• What do care workers think about dementia and dementia case-finding?

• Can care workers use a dementia case-finding tool to identify residents who are subsequently diagnosed with dementia?
Focus Group Findings

- Good knowledge of the signs and symptoms of dementia

- Positive and caring attitude to those with dementia

- Belief that dementia case-finding should fall under the role of the care worker as care workers know the resident well and can spot the signs

- Had opinions on each of the case-finding tools shown
Empowering Care Workers

To diagnose, the GP is the one but to notice, those that are close to him, the relatives or the carer workers or the nurses.
Design requirements of the tool

☑ Uncomplicated and straight-forward

☑ Accessible to people with English as a second language

☑ Recognisable and easy to follow

☑ Paper based

☑ Opted for shortest cognitive test (AMT-4)

☑ Include an ‘observational’ chart for context
The finished Product

Resident must give verbal consent to having their memory assessed in this way

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB: <strong>/</strong>/____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Home:</td>
<td>Care Worker:</td>
</tr>
</tbody>
</table>
Testing DeAR GP

• Care workers received a training session (1.5 hr)

• Care workers were provided with a guidance document

• Care workers were asked to use the tool with residents who appeared to show signs of memory loss or confusion but did not have a diagnosis of dementia

• Before using the AMT-4 care workers would gain informed consent from the resident, which implies establishing capacity first

• If the resident did not have clear capacity then the AMT-4 questions were not asked; only the observation chart was completed
Results

- New diagnosis
- Previous diagnosis
- Referred to memory centre for further Ax
- No further action
- Other

Total (23) Care home residents
Care Workers Feedback

‘We realised that the tool was simple and something that we could do without needing lots of training’

We knew residents who we thought had dementia but they were not diagnosed’

It was easy for us to use the tool with residents because they knew us and were familiar with us’
Endorsement and next steps

Alistair Burns, National Clinical Director for Dementia, included DeAR GP in his monthly communication to CCGs.

Dr Dan Harwood, London Clinical Network, Dementia theme
Alzheimer’s Society: DeAR GP will be co-branded and hosted by the Alzheimer’s Society.

DeAR GP is free to use; download www.dear-gp.org
Afternoon workshops
Care homes: implementing, sustaining and evidencing the delivery of quality end of life care
Overview

1. To summarise what we have learnt about the process of implementing and sustaining an end of life care programme in 123 care homes in five clinical commissioning groups

2. To consider audit as a mechanism for:
   - on-going learning
   - sustainability
   - evidencing care delivery
Wanted a research based facilitation model

• There was little evidence for the most appropriate model of facilitation for the GSFCH programme

• Previous studies highlighted the importance of ‘high facilitation’ and ‘action learning’ (Hockley 2005:2006:2010)

‘...it is a continuous process of learning and reflection, supported by colleagues, with an intention of getting things done.’

(McGill & Beaty, 2001)
Cluster Randomised Controlled Trial - outcomes of providing different models of facilitation of the GSFCH Programme

Arm 1
High facilitation and action learning
(n=12)

Arm 2
High facilitation
(n=12)

Arm 3
Observational
(n=14)

Nursing homes taking part in the CRCT (n= 24)
High facilitation and action learning ($n=12$) 83%

High facilitation ($n=11$) 27%

Nationally 13%

Observational ($n=14$) 7%
A mixed methods study - Facilitation of the GSFCH programme for end-of-life care in care homes

Key Messages

1. Facilitation needs to be provided locally, be structured, be proactive and involve a ‘being present’ model utilising a range of facilitation activities
2. Providing and receiving facilitation is hard work
3. To change culture requires personal mastery, organisational learning and membership of an appreciative learning system
The Care Home Project Team – Sustainability Initiative:

Ongoing training at 3 levels:

- All new staff starting at care home within 6 months
  - attend Introduction to Palliative Care Day
- Nurses/carers leading the End of Life Care Programme (Pilot)
  - attend 4-day City and Guilds Level 2/3 Awareness in End of Life Care Award course
- Home Managers
  - Half-day seminars for home managers x 4/year
  - Registered Managers Network Meetings x 3/year

On-going learning

- Visit care home every month to attend a coding meeting, a reflective de-briefing and a cluster teaching or role modelling session
- Data collection from every death in every care home and use of FPC Scale
- Support to maintain portfolios and accreditation
Nursing Homes Audit

Percentage of deaths in nursing homes

- 2007-08: 57%
- 2008-09: 67%
- 2009-10: 72%
- 2010-11: 76%
- 2011-12: 78%
- 2012-13: 77%
- 2013-14: 76%
- 2014-15: 79%
Residential Care Homes Audit

- Staff confidence
- Assess practice regarding assessment/management:
  - Pain
  - Depression
  - Advance Care Planning

Baseline audit

8 months later

Re-audit
Findings

Confidence when supporting a resident towards the end of life

Baseline
Re-audit
Findings

% Residents assessed with Depression assessment tool

- Baseline audit: 1%
- Re-audit: 48%
- Baseline audit: 7%
- Re-audit: 75%
Discussion

- Engagement of home managers and staff
  - Outstanding

- Involvement of external Health Care professionals
  - Requires Improvement

Outstanding | Good | Requires Improvement | Inadequate
“An Innovative and Integrated End of Life Care model for care homes”

Corinne Campion
Ash Kassaye
Louisa Stone
Susie Sutherland

Supportive Care Home Team
Royal Marsden Palliative Care
The Supportive Care Home Team

Part of The Palliative Care Service at The Royal Marsden

4 Clinical Nurse Specialists
Matron and Nurse Consultant

*Commissioned to Improve End of Life Care in Care Homes in Sutton*
Care Home Population of Sutton

203,048 Residents in Sutton

1077 Care Home Beds

74 Care Homes
Sutton Homes of Care (SHOC) Vanguard Model

NEW MODEL OF CARE

Integrated Care

Care Staff Education and Development

Quality Assurance and Safety

Supportive Care Home Team
Supportive Care Home Team involvement with Sutton Vanguard

Integrated Care
Clinical rounds with GP
Completion of CMC records

Care Staff Education
Attendance at care home forums
End of life Care Education Sessions

Quality Assurance
Member of the Joint Intelligence Group (JIG)
Support EOLC issues in Care Homes
End of life care model for care homes

- Education
- Clinical Rounds
- GP – Palliative Care Meetings

Specialist palliative Care
Monthly Education and Training Sessions

Theory – based around the EOLC process

- Recognition of Dying
- Communication & Advance Care Planning
- Last days of life – adapted Individualised care plan from local Hospice
- Pain
- Bereavement
- Multiple learning methods – case studies, scenarios, role play and reflections

- Development of Signposting tool -
Clinical round by CNS in Palliative Care

- Role modelling at every opportunity
- Complex cases liaison and referral to local hospice
- Advance Care Planning discussions with residents and families
- Symptom management
- Pain assessments – using validated pain assessment tools

- Sometimes with GP
GP – Palliative Care Meetings

Attendance by CNS at GP Palliative care meetings

- Ensuring care residents on the agenda
- End of life care plans in place
- Coordinate my Care records completed
# Key Performance Indicators (KPI’s)

<table>
<thead>
<tr>
<th>Key performance indicators (KPI’s)</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of residents dying in PPD</td>
<td>No data</td>
<td><strong>80%</strong></td>
</tr>
<tr>
<td>% of residents being offered Advance Care Plans</td>
<td>43.8% (n=196)</td>
<td><strong>70.8%</strong> (n=300)</td>
</tr>
<tr>
<td>% of residents with CMC record</td>
<td>23.9% (n=258)</td>
<td><strong>50%</strong> (n=501)</td>
</tr>
</tbody>
</table>

**204 teaching sessions** - 703 attendees to these sessions
Care Home EOLC Programme in Sutton

44 – Learning disability homes

17 Nursing homes

13 Residential Homes

Recently commissioned to pilot in 11 LD homes

Close working with Community Services
Recent CQC report – Inequalities in EOLC

People with a learning disability are likely to be identified as approaching the end of life late. This can lead to problems in coordinating end of life care and providing support to the person and family. Palliative care staff have a lack of knowledge around learning disabilities. Communication was identified as a significant barrier to good care. Difficulty in assessing pain.

2. Mercurio, Death by indifference, 2007
3. St Oswald’s Hospice, Disability Distress Assessment Tool
CQQ - What is important for good end of life care for people with learning disabilities

- “Important to have friends and family nearby
- Have privacy, peace and quiet, preferably not in hospital
- To be able to go outside
- Have support of a care coordinator”

*NHS England Steering Group for Learning Disability and Palliative Care*
Dying matters video
EOLC for people with Learning Disabilities

https://www.youtube.com/watch?feature=player_embedded&v=6eTuKY-VBaE