Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Places to Flourish

A pattern-based approach to foster change in residential care

Entering and Leaving

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Entering And Leaving

Introduction

People come to live in long-term care facilities from a variety of situations and for different reasons but for each person the move to nursing care is a major transition in their life. Ideally the decision to move to long-term care should be taken by the person in a fully informed manner, but in practice this may not always be the case. Some people will come direct from hospital because it has been decided that their care needs are best served in a continuing care setting. Others will come as the result of a crisis and may have been faced with the decision suddenly, for example after the death of a spouse, or after they have had a fall, and some will come as the result of decisions made by the family, with little or not input from the person. Not surprisingly then, clinical and other care issues of residents vary substantially. More generally, people who leave their homes and families to move into long-term care experience a sense of grief and loss, viewing it as a one-stop place before dying. Such feelings may not reflect the care within the facility but rather the sense of insecurity the person experiences at leaving behind all that is familiar to them: family; friends; neighbours; home; possessions;; and their daily routines, for the unfamiliar: a new home; communal living with strangers; a busy often noisy environment; and isolation from the wider community.

The more that staff do to create a loving, warm and homely atmosphere, the more likely it is that residents will make a positive transition. This means getting to know the needs and preferences of each new resident, learning about their life history, their interests, hobbies, likes and dislikes, creating a care plan and regularly updating it. It also means appreciating the range of family emotions that can accompany the move of a loved one to long-term care, providing appropriate support and a listening ear for the family, helping them to understand the process of long-term care and ensuring that all staff (day and evening staff)are familiar with residents. In this section we explore the different patterns associated with 'entering and leaving' long-term care.

These include:

- **coming to live in a long-term care facility** and the type of approach that comforts and supports individuals undertaking this major life event
- **leaving long-term care**, supporting good end of life care
- **visitors coming and going**, ensuring visiting is not something which is brief and limited to a few relatives, with children and extended family members reluctant to visit or to risk taking the nursing home resident out of the setting to participate in community life. Ensuring residents have access to private space where they can enjoy confidential visits from families and friends if they wish
- **staff coming and going**, modifying staffing patterns to reflect residents' needs and preferences
- **the kitchen**, offering flexibility in how and when residents eat; supporting communal living whilst also appreciating that people have not chosen the community and therefore not everyone will want to avail of communal facilitates and their wishes must be respected
- **outdoors**, spending time outdoors and facilitating residents' use of the space

Entering and Leaving: A Typical Example

Mary, an 80 years old woman, came to live in Laurel House two years ago. She is a widow and a retired art teacher. Mary is frail with scoliosis and arthritis and is unsteady on her feet and at high risk of falls. She has had two falls within the past years, the first happened when she was walking in her garden and slipped on the path, and the second happened when she fell down some steps at church, fracturing her pelvis. Mary has one daughter, one son, five grandchildren and a large circle of extended family and friends. Mary was not particularly happy about leaving her home to come to live in Laurel House, but she understood the reasons. In the personalised care assessment carried out with Mary prior to her coming to live in Laurel House, Mary told staff she enjoyed pressing dried flowers, painting and playing boards games with her grandchildren, but that she had significantly curtailed activities that she enjoys such as gardening and shopping because of her fear of falling. Mary has a warm personality but does not like to be addressed by her first name without permission. She doesn't like many of the programmes on television, preferring instead to listen to her favourite arts programmes on the radio.

When Mary lived at home she would often listen to children's art programmes so that she could try the same with her grandson at weekends. Sometimes her older granddaughter, Sarah, would stay over on the Saturday and drive her to Mass on the Sunday morning. Mary's faith is very important to her and she has never missed the Sunday morning religious service in her local church since she got marred 60 years ago. Mary also likes to cook and always bakes cakes and buns for her daughter and son. When she and her family had decided that she could no longer live in her own home, they had chosen Laurel House because it had a good reputation for care and it had a homelike atmosphere.

> *"It's so homely here, Mum settled in really well. There's not one thing in particular that I could point to, it's all the little things that make the difference; like knowing Mum gets up and goes to bed when she wants to, that Sarah can stay over and take her to church, that the television is not going all day with programmes that Mum hates, that the staff are aware of what dignity and respect mean to her in terms of daily living"*

Laurel House operates from the Teaghlach model which supports older people to continue to direct their own lives 'at home' supported by a consistent and valued team of health and social care staff. Under this model, the residential units become a home in all respects. Residents are encouraged to make choices about their daily routines; when to get up, what to wear, what activities they wish to be involved in, and how they want to participate in the management of their own health. The resident's plan of care includes a description of their preferred daily routine, their likes and dislikes in relation to food and any dietary requirements. It includes their preferences in respect to how they like to be addressed and what dignity, respect and privacy means to them in terms of daily behaviour and actions. This is important both in relation to any intimate personal care activities that staff carry out as well as residents' enjoyment of social activities. The care plan also includes details of residents' social interests and activities and how these are met, and any arrangements to attend religious services of their choice and for contact with relatives and friends. The dedicated care team monitor, review and co-ordinate care plans for residents and regularly update these to ensure the information they have reflects the resident's physical, social, and emotional needs and their preferred habits, activities and relationships, helping them to live comfortably and feel at home in the facility.

For Mary, this meant she could have her granddaughter stay over at weekends if she wished because Laurel House provided a room so that families can stay over. All the family were delighted with this especially as it meant Mary could continue to attend her local church on the Sunday. The large garden at Laurel House also meant that Mary could continue to enjoy working with dried flower and to begin going for walks and building up her stamina. To help alleviate Mary's fear of falling, a falls risk assessment was carried out on admission by a health care professional with appropriate skills and experience. Staff worked with Mary and her family to educate them about risk management and the interventions which work best to minimize the risk of falls and risk of injuries. Mary liked the suggestion of the gentle exercise programme offered by staff to develop and improve her sense of balance and encourage her to participate in the social activities she previously enjoyed before she fell.

The personalised care assessment completed with Mary and her family meant staff had exhaustive details about Mary's personality and all her care preferences, including her end of life wishes. Mary was adamant that she did not want to die surrounding by strangers but by those closest to her and preferably in her own home.

But Think . . .

The Challenges: a home-like, non-institutional, resident-directed model of care promotes autonomy and choice for residents and for those who work closely with them, but as residents' age and their health needs become more complex, meeting those needs requires enhanced personal skills of staff. Staff must have a good understanding and appreciation of age-related changes such as the reduction in working memory which often accompanies growing older and in the speed at which information is processed, the declines in hearing, visual acuity, and/or the ability to process sensory information.

Staff must be skilful in holistic responses and flexible in the approach they take to situations on the ground. Care homes are complex systems where people are both working and living and in the context of resource constraints, professionals trained in a long-accepted medical model may want to give up on the non-institutional, resident-directed model of care and revert to old habits and established ways of working (Sylvie et al., 1994). It is important the facility is a place for living, with good medical and nursing care supporting rather than dominating daily life (Brawley, 2006).

Reflective Activity

Think about an older person within your family, someone with whom you are very familiar and close to. Identify their likes and dislikes, their care preferences, including end of life wishes. Identify how they can be supported with regard to each so that they can continue to live their life in the way they would wish. What special skills do staff need to respond effectively to your loved ones care needs?

The Teaghlach Model

In the Teaghlach model, the Nursing Home is divided into domestic style units or households of 6-16 residents. The kitchen/dining room becomes the central focus of the household. Every effort is made to include residents in the rituals of preparing and eating meals. For some this may include assisting in the preparation of meals, for others it may about the sensory and social experience associated with family mealtimes.

The nurses' station no longer exists as the change in culture requires a different approach to 'observation'; designated space for confidential work is provided in a less overt way. Residents make most choices about their daily routines, ranging from when to get up, what to wear, what activities to be involved in, and how they want to participate in managing their health care.

Each household has dedicated staff who work almost exclusively in a single household in order to develop and foster relationships between staff, residents and residents' families.

The household team is non hierarchical and is accountable for all outcomes within the household. This team is supported by a mentoring group (Senior Managers e.g. Director of Nursing who support the groups to develop skills such as team decision making, conflict resolution, delegation and other leadership competencies and provide support through the provision of resources.

The households are the living quarters of the residents and residents receive care services within the household to support them to live with dignity and optimal independence. Other services are accessed as they would be if the residents were living in houses in the community.

Entering and Leaving: Patterns of Activity

People who have to leave their homes and families to move into a nursing home experience a sense of grief and loss, particularly a sense of loss associated with their independence. Having independence is something that most people have accomplished in their life. The prospect of losing it can be frightening for those contemplating life in a long-term care setting.

As already identified in the introduction to this section, the more that staff can help to make the person feel at home, the easier the transition to long-term care will be for the person. For this reason, it is vital to develop a person-centred care plan based on what is important to the person if life is to be good and what good support from their perspective looks like. Having quality conversations with prospective residents and their families to gather initial information about how the person wants to live and be supported enables staff to see things from the resident's perspective. This helps to identify what are the things that really matter when the person is supported to come to live in a long-term care setting - to have familiar furniture, pictures of family and friends, to maintain connections to the community, to know what way the person likes to start their day (e.g. Mary likes a cup of black tea, no sugar), to know they need help with and what good support looks like to them.

Over time, a picture emerges of the person's daily patterns, including mealtime preferences, the social activities they like and what their ideal bedtime routine looks like. Within the Teaghlach model, the personalised plan which evolves from this process acts as the main reference point for the care team who support the residents, with the challenges associated with creating a home-like environment distributed among nursing and non-nursing staff.

There can be no doubt that working within such a flat structure presents many challenges. Care plans written from the resident's point of view may be foreign to nurses not educated to develop a care plan in the resident's voice or not having previously worked in a facility with such care plans (Green et al 2009). Nurses may perceive that giving residents the choice of when to sleep and eat would conflict with their routines of giving medications according to prescribed schedules or their responsibility for residents' adherence to prescribed diets. In practice, while a more hierarchical structure may be effective when workload is heavy, evidence suggests better outcomes are associated with smaller hierarchies and non-specific job assignment (Rohrer et al., 1993).

Working in a non-hierarchical structure promotes creative ways of working and improves morale. To be effective, teams should ideally have clear goals that every member feels committed to and works collaboratively towards; effective communication of ideas and feelings; appropriate and effective decision-making procedures; a forum for debate where staff are encouraged to talk openly and honestly about their view and experience of working and caring for older people; a high level of trust, acceptance and support among members, and constructive management of power and conflict (Anantraman, 1984, cited in Singh 2000).

So when thinking about how to support people who come to live in long-term care settings, how to facilitate people with different care needs to live meaningful lives and to have a dignified death, we should think about the following issues:

Coming to Live in a Long-term Care Facility

Personalised Care, Choice / Independence

The first impression should be positive, communicating a message that it is a nice place to live. Think about the facility where you work. What were your first impressions of it when you walked through the front door? What did it feel like? Was it warm and pleasant and were the staff friendly and approachable? First impressions can have a lasting impact, so it's important to have a nice entrance which conveys a message of warmth and comfort.

Empowerment, Dignity / Respect

As noted earlier, people experience a wide range of emotions when coming to live in a long-term care setting. Being friendly and helpful to the resident and their family will help ease the transition for the person, instilling confidence that you can offer the level of service and attention they are looking for. Listen with interest to their concerns and be passionate about the work you do? This will reassure the person and their family and can be inspiring for other members of staff.

Spend time with the person and their loved ones to develop a person centred care plan. This shifts the focus from what the nurse thinks should be delivered to what the resident wants and is most comfortable with. Prior to admitting a person to long-term care, it is important to establish a clear picture of how the person wants to live and how they want to be supported in their new home. This means asking them what matters most to them? What makes them happy and fulfilled? What they look forward to and enjoy? What is important to them and how best staff can support them from their perspective?

Freedom and Choice

Autonomy / Independence

This process should gradually take the person thought their day from when they get up in the morning to when they go to bed at night, identifying all the things that matter to them. . . the cup of tea in a china cup, the daily newspaper, the morning telephone call to a daughter, which must be made at a specific time etc., and the events and activities which are a normal part of family life, such as shopping, enjoying a meal in a favourite restaurant, or, as in Mary's case, having a grandchild stay over at the weekend. Encouraging the person to exercise choice and to take calculated risks, maximises their control over their lives and empowers the resident.

Think about what matters most to you. How would you like to be supported to live in long-term care? How do you convert this into caring practice with someone who is coming to live in a long-term care setting? Think about a person you care for who is anxious about moving to long-term care. Can you think of some ways to reassure them? List some reassuring statements that you can use when you are gathering information for their personalised care plan.

Teamwork is an essential aspect of the Teaghlach approach to care. An effective team with good communication and an environment which promotes openness, creativity and cooperation has the ability to improve outcomes for residents. Good teamwork is built on relationships of trust, relationships between staff, between staff and residents and between staff and families. Relationships of trust promote communication and enhance continuity of care, facilitating person-centred care, and fostering a sense of community, positive outcomes, and consistently high resident and family satisfaction.

Can you think of someone you cared for that you established a good relationship with? How did you do it and what helped this process? Can you think of someone else you cared where this did not happen and why this was? Could you do something differently which would have changed this for

the better? Completing a personalised care plan for a resident needs input from many sources (e.g. the resident, the family, care staff, GP,). This requires care teams to work together and communicate often regarding the status of residents. Consider how you share information that ensures residents' wishes and preferences shape how they experience life in long-term care.

Leaving Long-Term Care, Supporting Good End of Life Care

Choice / Autonomy

End of life care is an important part of personalised support for older people living in long-term facilities. It is important to the person who is dying, it is important to their family and loved ones and it is important for the well-being of staff. End-of-life care for older people should be integrated into the everyday life and work of long-stay facilities (O'Shea et al., 2008). Think about the residents where you work; can you identify those residents who are nearing the end of their lives? Think about 'good end-of-life care' and what it means within the following broad areas—physical comfort, mental and emotional needs, spiritual issues, and practical tasks.

Respect / Dignity

The Forum on End of Life in Ireland, by the Irish Hospice Foundation, called for openness and transparency in the way end-of-life decisions are made and a focus on good communications practice by staff to deal with often difficult conversations. Do you talk with your residents about where they would like to live and die? Even something as simple as body language is important, use body language that shows caring and respect. A gentle touch, holding the person's hand and just spending time shows caring. What support do you provide for families before, during and after the death of a loved one?

Education / Training

Have you received appropriate training to support residents who are dying and their families? Evidence points to the importance of staff readiness, with better outcomes associated with staff feeling prepared for the death of a resident and having experience and training (McKeown et al., 2010)

Staff Coming and Going

Teamwork / Consistent Staff Assignments

A long-term care facility is home to people who live there but, to those who provide care in such a setting, it is a busy working environment. The 'community' coming and going in such environments might include: nurses, health care assistants, housekeeping staff (cleaners, cooks), clergy, recreational staff, secretaries, physiotherapists, speech therapists, dieticians, GP, residents, family members and friends of residents. To create a non-institutional, homelike environment in such a setting is challenging. For staff, the expectation to meet standards of care is compounded by culture change efforts toward homelike environments which mean they are expected to understand topics in which they may have received little or not formal training. An important starting point is therefore to support quality relationships between staff and residents, for example, by avoiding staff rotation. When staff are rotated it is difficult for them to develop relationships with residents or co-workers. Where staff are rotated, they have to take the time to understand the needs of residents with whom they are unfamiliar and they have to balance this with working with different members of staff.

In the facility where you work, are residents cared for by consistent teams? If not, what do staff members experience when their work is routinely changed? How does that affect their relationship to their work? What do residents experience when they have frequent changes in staff? How does teamwork help improve care and relations between staff and residents and between staff? Think about the preferred schedule of staff. Figure out when the busiest times are in accordance with the residents' patterns. Adjust schedules to have the help that is needed during those times. Encourage teams to work with each other to provide back-up for when schedules need to change. Identify who enjoys floating so that the team will not be destabilised by making everyone float. Provide constructive feedback on interactions with residents and families and between staff. Foster a culture of trust among staff by providing opportunities for staff to communicate with management.

Visitors Coming and Going

Sense of identity

The presence of family and friends in long-tem care facilities is central to residents' sense of identify. Regular visits from family and friends can help maintain residents' personal relationships with others outside of the facility. It is important, therefore, to ensure that visiting is not something which is brief and limited to a few relatives. Based on the wishes of the resident, children and extended family members should also be encouraged to visit and or to take their loved one of the setting to participate in the live of the community if the resident so wishes.

Respect

Do you operate a policy of open visiting in the facility were you work? Open visiting results in more positive relations between families; visits can be spread out over the week and residents are not overwhelmed with a large crowd at the one time. Residents often enjoy having a guest for a meal? Do you encourage relatives, children and friends to join residents at mealtimes to make meals more special? Do you encourage visitors to take the individual outdoors or to go for a walk? Are private, comfortable spaces available where residents can take their visitors for private conversations or to discuss personal matters or enjoy reminiscing? Concentrate on the quality of visiting; a visit should be pleasant and a break in the person's daily routine.

Privacy

Think about how you enter the private space of residents. When people visit you, they come to the door and knock or ring the doorbell and wait to be invited in. A resident's room is their home. You should always knock, ask permission to enter and wait for a response. If the resident does not respond, then announce yourself before walking in.

The Kitchen

Autonomy

The kitchen, is the hearth of the home, the place where people gather to share a meal, have a cup of tea, read the paper and enjoy a leisurely chat. The kitchen conjures up memories of food. It is used to cook, entertain and eat. At home, people come and go to the kitchen when they want. Residents in long-term facilities who are not confided to the bed should have opportunities to enjoy the home comforts of access to the kitchen. They should have the opportunity to enjoy a snack when they feel like it; or to sit and watch staff preparing a meal and to enjoy the smell of foods.

Health and Safety

Think about the facility where you work. Does it feel like home? Is it decorated like home, with soft colours and personal belongings of the people who live there? Do residents have access to a kitchen? How can risks associated with the kitchen be eliminated e.g. the risk of a resident getting burnt? How can residents be made more aware of basic kitchen safety, or how to use the cooker safely?

Autonomy / Independence

Older people have the rights to make choices and to take risks in their life even if they can no longer live in their own home. The need for staff to ensure people are kept safe should therefore be balanced with residents' rights to a good quality of life and to take risks.

Privacy / Respect / Dignity

Do you encourage your residents to bring in some of their favorite possessions to help create a kitchen with feels homely? For example, a favourite cup, or a favourite chair can encourage fond memories or carry symbolic value of personal and family history. The main point here is that improving quality of life for this group is often about making simple changes.

Outdoors

Quality of Life / Sensory Experiences

Being outdoors for recreation activities is often considered an important part of leisure to enhance one's quality of life. For an older person living in long-term care, spending time outdoors is influenced by the environment and the ethos of care. To what extent do your residents use outdoor space? Is the garden safe for people to walk in, for example, no steps and pathways that are inaccessible for wheelchairs? Are there seats at strategic points with sheltered and shaded areas to enable residents to spend time outside? Are there raised flowerbeds, herb gardens or a greenhouse to make it easier for residents to take an active interest in the garden? Is the garden scented to make it attractive to residents who are visually impaired? Window gardening, small herb gardens planted in plant pots and hanging baskets are all accessible even for the most vulnerable residents.

Are families encouraged to take their loves one out of the home to enjoy visiting to the local shops, cafes, theatre etc? Is there a local bus service which residents, families and friends can use and are they made aware of this facility? What local schools, youth groups, young people´s church groups or other organizations can you identify which you could contact to organise visits to the home to keep residents connected to, and interested in, the community.

Suggested Areas for Place and Practice Improvement

In considering the entering and leaving patterns discussed above, you may have identified some aspects which would benefit from changes. To promote and facilitate positive experiences, you may want to consider these as potential areas to address. The following suggestions may be helpful when you are considering changes:

- Identify the 'community' involved in the facility where you work
- Identify ways to make sure that everyone is able to obtain information about care and life in the facility, and are able to contact you in ways that meets their individual needs. Accessible communications are essential for people to be able to give their views and experiences about the facility
- Familiarise the community about the household model of care and develop ways to educate them on what the model involves. Hold meetings, discussion groups, meet with resident committees, family, etc
- Create a committee to represent the voices of the different members of the community and discuss possible ways of making changes and how to monitor interventions
- What are the resource implications?
- Can some changes be implemented in a shorter timeframe than other?
- Identify adjustments that can be made to staff rotas to implant consistent assignment using **www.maseniorcarefoundation.org/.../Enhancing_Quality_of_Life_Through_Consistent_Assignment.aspx**
- Explore the potential to introduce the Teaghlach model using: A Practical Guide to Transform Institution to Home: A leadership book to assist providers by providing a change framework based on the Norton/Shields Change Matrix: Self, Leadership, Organizational and Environmental Transformation

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Notes

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