Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Places to Flourish

A pattern-based approach to foster change in residential care

Personal And Therapeutic Care

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Introduction

> *I enjoy getting my hair done. I was a brunette when I was young you know. I don't bother with colouring my hair as the grey ones are as easy to carry as the white! I like living in this house . . .*

Creating a person-centred environment for living and delivering person-centred care in a residential setting challenges many assumptions that we may hold about how care is delivered. In the normalising of residential care environments, one of the biggest challenges is that of creating an environment that supports the effective delivery of person-centred care whilst at the same time avoiding the creation of a 'clinical' setting. For the majority of older people, the reason why they are in a residential facility is because of some significant change in their health status that requires them to have access to 24 hour personal or therapeutic care. In this section we will explore patterns associated with personal and therapeutic care needs and issues to consider in the giving of effective person-centred care whilst at the same time operating within an overarching normalised setting. The goal of person-centred and evidence-informed care in a residential setting is to maximise the person's independence, ensure freedom of choice, provide safety and protection in order for them to realize their potential for physical, social, and mental well-being.

Personal and Therapeutic Care: A Typical Example

Tess is 96 years old and lives in Hillside residential care facility. It is a large multi-level facility ranging from independent living bungalows through to nursing home care. Tess has lived in Longacres Hillside for 12 years when she originally lived in one of the assisted living houses. She has dementia which has been progressing rapidly and reached a stage last year where Tess was no longer able to remain in her assisted living house. She became increasingly disorientated, highly anxious, distressed and with increasingly unsteady mobility. She had been found on a number of occasions wandering in the grounds searching for the toilet, she had fallen whilst getting out of her chair on other occasions and was showing increasing signs of being anxious on her own. Tess had been struggling to attend to her hygiene needs and had developed a fungal sore beneath her breasts. Following

discussion with her family, it was agreed that Tess would move to the nursing home facility on site where she would have access to 24 hour care.

During the first week of her stay in the nursing home facility, Tess had a thorough re-assessment of her care needs. Although she had a care plan to support her in her assisted living house, this largely focused on supporting her with personal care in the morning and evening and with ensuring that aspects of her home were 'safe' for her to continue living there. Her assessment revealed a significant deterioration in her memory functioning, a reduced independence in attending to ADLs (Activities of Daily Living), weight loss and significant reduction in her mobility (unsteady in transferring from sitting to standing, shuffling gait and loss of balance).

As part of her assessment and care planning process a multidisciplinary case conference was held as well as a care planning meeting with Tess, and her son and daughter who lived in the area. A care programme was agreed that ensured the following:

- However possible, Tess' potential for independence would be maintained.
- Her usual patterns of living would be protected wherever possible – such as her morning and evening routine, her food preferences, her hygiene patterns and routines, her social engagement patterns.
- Tess would be involved in decisions about her care and the care team would draw upon their knowledge gained from the development programme they had undertaken in 'person-centred dementia care' to observe her levels of 'well-being', as an indicator of satisfaction with her care.

A care plan was devised that identified the aspects of the care plan that required different kinds of inputs from the care team and that integrated the personal, social and therapeutic aspects of Tess' care needs:

1. Tess would only be *directly* helped with those aspects of her personal care that she could not do for herself – specific aspects of personal hygiene, putting on incontinence wear and underwear, fastening cardigan buttons, tying shoe laces and putting on her makeup. For other aspects of her care she would be *supervised*, following a plan of care devised by the care team with Tess and her family.
2. The registered nurse would administer Tess' medications and would treat the sores on Tess' breasts prior to her leaving her bedroom in the mornings and when she retired to her room at night. This would be done when most appropriate in Tess' morning routine.
3. Tess had a specialist physiotherapy assessment for her mobility and as a result had her bed and chair height adjusted and was equipped with a walking aid. Her care plan included supervised walking from her bedroom to the kitchen/dining room and between the kitchen/dining room and lounge area. Every other week, the registered nurse reassessed her walking by observing one or more of these activities and made adjustments to the care plan as necessary.
4. As a part of the social and therapeutic activity programme of her care plan, Tess would be invited to prepare part of her own meals in the kitchenette, with supervision.
5. Once weekly, Tess had a leisurely bath in the afternoon and was helped by the care assistant and the registered nurse (as this was a time for the nurse to reassess her physical and psycho-social functioning as well as attend to particular care needs, such as skin integrity, nails and care of the breast sores). Tess loved this part of her week and visibly relaxed when she entered the bath of water bubbling with her own bath foam (a brand she had used all her life). The bathroom was well heated, had adjustable lighting and was decorated to create a relaxing ambience.
6. After her bath, Tess had a shoulders, hands and foot massage in the 'complementary treatments room' and afterwards she liked to spend the rest of the evening in her bathrobe in her own bedroom.
7. Tess went to her daughter for lunch most Sundays after mass. Her son would collect her, take her to the church and then on to her daughters for lunch. She usually returned in the early evening when she enjoyed a dry sherry by the fire in the lounge and happily chatted about the events of the day.

But Think . . .

The Challenges: Tess is one of 10 residents in the section of the nursing home facility where you work. All the residents have different types of care needs and all require different amounts of inputs in order to meet their care needs whilst at the same time maximising their self-care potential. A couple of residents' need all their care needs to be met and are unable to mobilise. Not all residents are as amenable to the devised plan of care as Tess and some are reluctant to cooperate with planned care – the care team have tried to work out reasons for this but as yet have not found a solution. Usually there is only one registered nurse on duty in your section of the nursing home and it is challenging to meet the individual requirements of residents when care assistants call for their particular input – this sometimes leads to friction in the team. Despite having a process in place to discuss and agree the care plan for individual residents with their family members, sometimes family members make demands that are not consistent with the plan of care. The team worries about how they meet HIQA standards and get concerned that an unannounced inspection would suggest they are disorganised because there is no apparent routine. The kitchenette is a fantastic resource but it requires the care team to be hyper-vigilant about health and safety and for risk assessments to be in place. Not all members of the team are committed to these ways of working, despite the leadership shown by the care group managers, and sometimes they revert to task-based and routined care, such as doing all the residents' medications at the same time, not negotiating when specific treatments are undertaken and treating meals as a task rather than an individualised and social occasion. When challenged they argue that the residents don't notice as they are confused – this cause friction in the team.

Reflective Activity

Consider your immediate response to the 'typical example' above – do you think it is idealistic and unachievable in your particular setting? Is it the kind of care you would want to give but don't feel you can? Why not? Consider the challenges identified above. Do any of them sound familiar to you? What can you do within your 'sphere of influence' to address some of these challenges and move towards a more person-centred approach?

Personal and Therapeutic Care: Patterns of Activity

There is little doubt that attending to personal and therapeutic aspects of residents' care is a dominant part of the role of a care team in residential care settings. As already identified in the introduction to this section, if residents didn't have such care needs then it is unlikely that they would be in a nursing care facility in the first place. However, the challenges associated with creating a normalised/homely environment whilst at the same time providing for high levels of care need to people with chronic physical and mental disabilities need careful consideration.

Fundamentally, the challenges raise issues about the roles of different members of the care team and the delivery of health care in a household model of care. The argument usually focuses on 'dependency' levels of residents in care homes that operate from a household/social model of care and the reality of meeting complex health and social care needs with such environments. There is little evidence to suggest that the meeting of high levels of care is not possible within such models and indeed, evidence would suggest that the 'dependency levels' in care homes that work in this way is no different to those with a more traditional/clinical mode of operating.

Therapeutic Care: is evidence-informed goal directed care that is aimed at minimising the symptoms of deterioration in health statues and on advancing the best interest and outcome for the resident.

Personal Care: is physical assistance with activities that maintain health, such as eating or drinking, toileting, washing or bathing, dressing, oral care, the care of skin, hair and nails, or the prompting and supervision of a person to undertake these activities.

Nursing is at the heart of health care delivery in nursing care facilities. They provide the 24-hour delivery of therapeutic care usually in liaison with other multidisciplinary colleagues (such as, general practitioners, occupational therapists, physiotherapists, podiatrists) and in collaboration with care team colleagues in the setting itself. However, the role of the nurse in residential care settings is hotly debated and the remodelling of residential care for older people brings with it an associated fear of the loss of the registered nurse input.

However, recent research highlighted the key role of the registered nurse in the delivery of therapeutic care (AIGNA/Heath 2010)*. In a review of the international literature pertaining to the role of the registered nurse in residential care, Heath (2010) suggested that "the literature generally highlights a lack of clarity in how, in practice, the roles of registered nurses and care assistants are distinguished. Importantly, most of the studies observing the work of registered nurses and support staff in residential care, including research across Ireland, categorise their contribution according to the 'tasks', 'activities' or 'interventions' they undertake". Heath further suggested that because these activities 'seem' to be the same when carried out by either a registered nurse and a care

**AIGNA: The All-Ireland Registered Nurses Association is dedicated to supporting nurses who work with older people in Ireland. Its focus in on being a leading national association set within an international context, demonstrating tangible influences on Gerontological nursing policy, strategy, research, education and practice*

"I hated when I became incontinent. I knew it was happening but I didn't want to admit it. Eventually it became unbearable and the public health nurse assessed me and provided me with really good incontinence pads. Changed my life it did. So I was really worried when I came in here that I wouldn't be able to continue with the pads. However the girls have been fantastic – they did another assessment, agreed with me a routine for going to the toilet that means I am dry all day and I only need the pads at night. It's fantastic"

assistant then there is scope to reduce the numbers of nurses in such settings. The research undertaken by Heath (2010) on behalf of AIGNA highlighted the contribution that registered nurses make to the lives of older people in residential care and the importance of this role in ensuring therapeutic care for older people. However, we are at the forefront of service change, redesign and the development of new ways of practicing. The WHO Policy Framework on Active Ageing (WHO 2002) emphasises the need for people to be enabled "to realize their potential for physical, social, and mental well-being throughout the life course and to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security and care when they require assistance". Ensuring that older people who are 'frail' and who have care needs have the same right of access to opportunities that enhance their physical, social and mental wellbeing is critical.

Whilst the need for nurses to provide therapeutic care is indisputable, the model within which this is done is important. Therapeutic care set within a social model integrates the therapeutic and personal aspects of care. It doesn't privilege the 'health care intervention/task' as the central focus of practice, but instead views these tasks as essential elements of an overall approach that focuses on realizing the potential of older people for physical, social and mental well-being whilst at the same time assuring their protection, safety and security. So the example of 'Tess' provided earlier is a typical example of how a care team that is not focused on 'roles and tasks', but instead focuses on realising the person's potential can work together in an integrated way.

So when thinking about how to deliver high quality person-centred evidence informed therapeutic and personal care to residents in a care setting we should think about the following issues:

Person-Centred / Individual

Providing personal and therapeutic aspects of care probably constitutes the significant focus of work in a residential setting for older people. However, for the resident this should just be one part of their life experience and indeed should be the part that enables them to live a fulfilled life. In what ways do you or can you make personal and therapeutic care more person-centred in your setting? What happens in the morning? What happens at night?

Autonomy / Independence

Do the established ways of working constitute a 'typical institutionalised' approach, i.e. morning time focuses on washing and dressing; afternoon on social activities, treatments or care routines and evening on getting ready for bed/settling down for the night? Do you know the patterns of individual residents? Does their individualised pattern follow this institutionalised pattern or are there differences?

Freedom and Choice

What are residents able to make? For example can they choose what time they have their breakfast? Can they choose what activities they participate in? Are these choices limited by the established routine of the care setting – ideally, the routines of the care setting should reflect the individual patterns of the residents.

Flexibility and Adaptability

Think about how you work as a team and how much flexibility and adaptability there is in the team. Ideally, whilst everyone in the team will have a designated role as set out by the individual job descriptions, in an effective team, these roles become 'blended' in the interest of ensuring flexibility of care delivery and adaptability of roles. Whilst some tasks can only be done by a person with the correct knowledge, skill and expertise and some may be governed by statutory regulations and professional codes of conduct, there remain many aspects of care delivery that can be undertaken by all members of the team. Further, statutory regulations and professional codes of conduct usually allow for the 'delegation of duties' to others once an assessment has been undertaken, a care plan put in place and a plan of supervised practice agreed. How do you and the team work? Are you focused on who does particular tasks or are you focused on blending roles according to the individual resident care needs as set out in their care plan?

Safety and Protection

Do you work with a particular group of residents over a long period of time, or are you allocated different residents each day or allocated work according to particular tasks? The most effective way of delivering person-centred care is through a model that ensures a team work with a group of residents over a long period of time. In this way, you get to know the residents intimately, you form relationships as 'people' rather than 'care giver and care receiver' and you develop effective adaptable, flexible and integrated ways of working.

The use of life-review documents are really helpful in enabling you and the team to discuss individual patterns that residents have for their personal and therapeutic care and in planning individualised programmes of care. Care reviews with residents and families are important structures for reassessing the effectiveness of care programmes, ensuring freedom of choice and a flexible approach. What communication structures and processes do you have in place?

Privacy and Dignity

It should not need to be said that care provided to residents should be dignified and should respect their need for privacy. Dignity is a human concept and is directly linked to concepts of caring and holistic care. Being treated with dignity is a human right. Whilst as a concept, dignity is hard to define, we all know it intuitively and we tend to define it according to its presence or absence in our experiences. Indeed, not paying attention to dignity in care is one of the main reasons for families to complain about standards of care (Yalden & McCormack 2010). Privacy tends to go hand in hand with dignity – making a resident use a commode in a public space would show a lack of respect for privacy but would also constitute a loss of dignity.

How do you ensure that privacy and dignity are respected in the provision of personal and therapeutic care? Do you know what values the person holds about things such as privacy? Do you know how the person feels about being seen naked for example? These are important aspects of ensuring privacy and respecting dignity. In what other ways do you ensure privacy and protect dignity?

Character – Harmony Between People and Purpose

So far we have focused on dignified care for residents, but what about the dignity of team members? It is increasingly recognised that team members have to be treated with dignity, treat each other with dignity and respect each other's dignity if a person-centred culture is to be maintained (McCormack & McCance 2010). Helping team members to develop professionally and personally is a key part of this. Is your role defined by the tasks you do in your job or is it 'blended' with other roles, with each person working in harmony with the other in order to provide person-centred care? Are there opportunities for you to develop new skills and take on new roles? A person-centred culture is one in which, there is the right mix of staff in place to do the job effectively; where the whole care team share power by participating in decisions that impact on how everyone experiences the care home; where there are effective staff relationships, enabled through team meetings, supervision, support, challenge and reflection; where the organisation is supportive of the team, demonstrated through a commitment to learning and

development, change, innovation, risk taking and a high quality of experience for residents and teams. How does your setting reflect these values? What can you do to enable (more of) these values to be realised?

Social or Therapeutic Relationships

Therapeutic and social relationships are key parts of the relationships between a care team and residents. Whilst there is a body of literature that defines therapeutic relationships, the distinction between therapeutic and social relationships is 'fuzzy' and it would be wrong to view these as separate things when working with older people. However there is a large body of international literature in nursing that demonstrates the importance of therapeutic relationships to effective care with older people, where a therapeutic relationship is viewed as one that:

> *". . is grounded in an interpersonal process that occurs between the nurse and the client(s). Therapeutic relationship is a purposeful, goal directed relationship that is directed at advancing the best interest and outcome of the client"*
>
> **RNAO, 2002**

Having a model of care in place that maximises continuity of care, where staff are supported with education, opportunities for learning and professional development, where reflective practice is in place and where there are opportunities to advance clinical and therapeutic expertise are all key elements of an effective therapeutic relationship. Providing therapeutic and personal care offer essential opportunities for nurses to build therapeutic relationships with residents and indeed providing personal care is a way in to the formation of therapeutic relationships between nurses and patients/residents. How do you value therapeutic care? Do you see these aspects of care as necessary tasks or as key opportunities to engage with residents as 'persons'?

It is becoming increasingly common for residential care settings to employ staff who have a specific focus on facilitating social relationships among residents, sometimes referred to as 'activities helpers'. Whilst these are valuable opportunities for residents to engage in meaningful activity that can enhance their relationships with other residents, stimulate cognitive activity, retain essential skill and expertise, and reduce boredom, these should not be viewed as the only opportunities available for meaningful social relationships.

The provision of personal and therapeutic care provides ample opportunities for social relationships to be developed, maintained and enhanced. For example, most of us would agree that preparing and sharing food with others is a wonderful opportunity for social engagement, conversation, laughter, fun and 'chat'. Tidying/washing up after meals continues this engagement. What opportunities are there for you to 'normalise' activities with residents that otherwise may be seen as 'staff tasks'?

Quality of Place and the Physical Environment

Having the facilities to support quality provision of personal and therapeutic care is important. Institutionalised environments with for example, dormitory-type bedrooms, few bathrooms and toilet facilities, large 'day-rooms' and long corridors do little to enable continuity of personal and therapeutic care or the quality of the care experience. However, there is much that can be done to enhance these environments and minimise the feeling of 'institution'. For example, sub-dividing large spaces through the use of dividing panels, clever use of furniture and the change of use of spaces can enhance the care environment. The use of colour, light and heat can enable spaces to become ones that enhance the quality for the care experience. What opportunities are there for you to enhance the environment where you work? Can you identify some simple changes that could be made and that would make the setting more 'homely'?

Sensory experience (light, colour sound, scent, taste, touch, feel, warmth/air)

Suggested Areas for Place and Practice Improvement

In considering the patterns in the previous section, you may have identified some aspects of practice that could be changed or developed or changes to the environment that may enhance the care experience or indeed team developments that could improve the overall quality of care. So you may want to consider these as some potential areas to address in order to enhance the experience of personal and therapeutic care for residents and the care team. These ideas are in no way exhaustive, but they may provide you with some options for consideration:

- Discuss with your colleagues the definitions of personal and therapeutic care offered in this resource – what do they mean to you as a team? In considering these definitions, do they raise issues about how you work as a team? Consider how you might address these issues?
- Do you have a shared set of values about 'care' in place? If you don't have a shared set of values, consider using the process set out in the 'Values and Beliefs Template' to develop a values statement. When you have these values developed, consider what adjustments you may need to make to your ways of working in order to operationalise these values.
- Do you know what model of care is used in your care setting? Does the model of care reflect the espoused values of the team/setting? For example, is the model one that is based on person-centred principles where care inputs from different team members are organised around the needs of residents and their particular patterns? Do you work with the same group of residents over an extended period of time? Do you have 'named residents' that you are responsible for? Do you use a 'buddy' system, i.e. where you work with another care worker as a critical friend and colleague? Consider what adjustments could be made to your model of care to maximise person-centredness.
- Identify from life review documents residents' usual care patterns and adjust individual care plans to reflect these patterns.
- Set up a meeting with other care team members to discuss residents' personal care patterns and identify areas of similarity and difference. Consider ways in which you can adjust the way personal care is organised to take account of these patterns and ways in which therapeutic care can be integrated into these patterns.
- Initiate 'on the job' training to develop knowledge and skill in doing key aspects of care in a person-centred way, e.g. helping with transfer, assisting with meals, using hoist etc.

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