Final Report

Exploring the experiences of staff, residents and families in care homes to support the design of new care homes in West Dunbarton

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Introduction

West Dunbartonshire Local Authority is planning to build 2 new large care homes for residents. Planning is underway to design care homes fit for purpose. My Home Life Scotland at the University of the West of Scotland were commissioned by the Local Authority to explore the experiences of living, visiting and working in care homes to help inform the design process.

This exploration was grounded in the extensive evidence base, methodologies, tools and techniques developed through a UK-wide initiative called My Home Life. My Home Life has been working for several years to foster stronger relationships between residents, families, care home staff and the wider community to create enriched care environments and to improve the quality of life for all.

In addition, the analysis drew upon the Talking Points Outcomes Framework for Older People Living in Care Homes, developed through academic and practice-based work in Scotland through the Joint Improvement Team. The incorporation of a specific focus on personal outcomes for care home residents supports the planning, design, ongoing delivery, monitoring and improvement of care home services using nationally recognised criteria that are both meaningful and measurable.

This report describes the approach taken and shares the richness of the findings, before considering the implications for the new care home design, attending to both the physical and human infrastructure.
The Evidence Base Underpinning the Work

My Home Life

My Home Life (MHL) is a UK-wide initiative to promote quality of life for those living, dying, visiting and working in care homes for older people. West Dunbartonshire Local Authority has funded a cohort of Care Home Managers on the year-long My Home Life Leadership and Community Development Programme as part of the Reshaping Care for Older People initiative from August 2013 to August 2014.

The national MHL programme is led by City University (Research Group on Quality of Care for Older People) in collaboration with Age UK. It has the support of the Relatives and Residents Association and all national provider organisations that represent care homes across the UK. In Scotland the programme is led by University of West of Scotland (UWS) in partnership with Scottish Care and Age Scotland.

My Home Life is a social movement that seeks to ‘make a difference’. It is a collaborative scheme bringing together organisations that reflect the interests of care home providers, commissioners, regulators, care home residents and relatives and those interested in education, research and practice development.

The aim of MHL is to promote quality of life for people living, dying, visiting and working in care homes for older people, through relationship-centred and evidence based practice (www.myhomelife.org.uk). It uses an appreciative inquiry (AI) approach that focuses on what works well and identifies strategies for doing more of what works well. It is an exciting philosophy for development in that its starting point is that in every organisation something works well. Thus, rather than focussing on what is not working well, the approach sets out to establish strengths which re-energisces and re-engages people to challenge the status quo and take forward plans for improvement.

Best Practice Themes

MHL has worked with over 60 academic researchers from universities across the UK to develop the evidence base for quality of life in care homes. The review of evidence explored ‘what residents want from care homes’ and ‘what practices work in care homes’. Eight best practice themes were identified which were then translated into a conceptual framework for use by the care home sector to inform and support practice. Sorted into three broad categories, the eight themes are:

Personalisation

1. Maintaining Identity: Working creatively with residents to maintain their sense of personal identity and engage in meaningful activity.

2. **Sharing Decision-making**: Facilitating informed risk-taking and the involvement of residents, relatives and staff in shared decision-making in all aspects of home life.

3. **Creating Community**: Optimising relationships between and across staff, residents, family, friends and the wider local community. Encouraging a sense of security, continuity, belonging, purpose, achievement and significance for all.

**Navigation**

4. **Managing Transitions**: Supporting people both to manage the loss and upheaval associated with going into a home and help them to move forward.

5. **Improving Health and Healthcare**: Ensuring adequate access to healthcare services and promoting health to optimise residents’ quality of life.

6. **Supporting Good End of Life**: Valuing the ‘living’ and ‘dying’ in care homes and helping residents to prepare for a ‘good death’ with the support of their families.

**Transformation**

7. **Keeping Workforce Fit for Purpose**: Identifying and meeting ever-changing training needs within the care home workforce.

8. **Promoting a Positive Culture**: Developing leadership, management and expertise to deliver a culture of care where care homes are seen as a positive option.

**Relationship-Centred Care and the Senses Framework**

Underpinning the evidence base is the importance of Relationship-Centred Care and the Senses Framework. Not to be confused with Person-Centred Care, which tends to focus on individual service users in promoting their independence and consumer choice, Relationship-Centred Care focuses on developing positive relationships between older people, relatives and staff as interdependence is seen as an important ingredient of quality in care. For relationships within a care home to be good, consideration must be given not only to the needs of individual older people who live and die in the home, but also to the needs of relatives who visit the home and the staff who work in the home. Empirical research in long term care settings found that older people, relatives and care home staff need to feel a sense of:

1. **Security** – to feel safe
2. **Belonging** – to feel part of things
3. **Continuity** – to experience links and connections
4. **Purpose** – to have a goal(s) to aspire to
5. **Achievement** – to make progress towards these goals
6. **Significance** – to feel that you matter as a person
Talking Points: Outcomes Framework for Older People Living in Care Homes

West Dunbartonshire Local Authority was keen to embed a specific focus on personal outcomes for care home residents within this work, both to inform the new care home design and as a basis for identifying and improving outcomes for residents going forward.

Since 2006, the Joint Improvement Team’s **Talking Points Personal Outcomes Approach** has provided a clear focus for activity around outcomes and personalisation through participation in Scotland. The approach has been developed through a seven year programme of knowledge exchange and action research, which in turn built on two significant programmes of academic research into the outcomes important to people using care and support services. Initial activity around the development and implementation of **Talking Points** focused on adults living in the community, but in 2010 further work was carried out which verified the applicability of the approach in care home settings and culminated in a new **Outcomes Framework for Older People Living in Care Homes**. The 20 outcome domains or categories within the framework are described at Appendix 1 and fall into 3 main types:

**Change Outcomes** relate to (time-limited) improvements in functioning or physical / emotional wellbeing that individuals are seeking, often from a particular service or support

**Process Outcomes** relate to the impacts of the way that care and support are provided and position the intrinsic value of reciprocal and mutually respectful caring relationships centre stage

**Quality of Life Outcomes** are the aspects of a person’s whole life that they are working to achieve or maintain in partnership with care services and other forms of support, formal and informal

Although the research underpinning **Talking Points** found considerable agreement between individuals as to the overarching outcomes that were important to them in life, what this looked like for different individuals varied enormously. Taking a **Personal Outcomes Approach** requires that you start with the priorities, needs and aspirations of the person and work creatively towards them, drawing on a range of resources, including the strengths and (retained) abilities of the person.

**Talking Points** is grounded in the understanding that quality of life outcomes often cannot be achieved by (or attributed to) a single service provider, but rather require the provider, the individual, families and social support networks, the local community and the wider care system to work together, and to understand, respect and value each other’s contributions. It shares My Home Life’s commitment to improving relationships between and quality of life for everyone involved in caring situations.

While prioritising **engagement and participation**, the **Talking Points Personal Outcomes Approach** also encompasses systematic **recording**, drawing upon the **Outcomes Framework** to support the categorisation and aggregation of personal outcomes. This in turn supports **use of outcomes information** (crucially including qualitative information) in decision making processes at individual, service and organisational levels for a variety of purposes. Achieving personal outcomes depends upon an appropriate physical and human infrastructure. Informing the new care home design is therefore a critical application of outcomes data.
Developing an Analytical Framework for West Dunbartonshire: Synthesising the My Home Life Themes, the Senses Framework and the Talking Points Outcomes

In order to inform the new care home design in a way that is consistent with the principles of Relationship-Centred Care, that makes best use of the extensive thematic evidence base for the care home sector held by My Home Life, and that also enables personal outcomes for care home residents to be discerned and expressed in the language of Talking Points, a blended analytical framework was developed, as detailed below:

### Quality of Life Outcomes:

<table>
<thead>
<tr>
<th>Talking Points Outcome Domain</th>
<th>My Home Life Theme(s)</th>
<th>Senses</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel safe and secure</td>
<td>All 8 Themes Contribute</td>
<td>Security</td>
</tr>
<tr>
<td>I have a nice place to live</td>
<td>Maintaining Identity</td>
<td>Security</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Achievement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[Enjoyment]</td>
</tr>
<tr>
<td>I see people</td>
<td>Creating Community</td>
<td>Belonging</td>
</tr>
<tr>
<td></td>
<td>Maintaining Identity</td>
<td>Continuity</td>
</tr>
<tr>
<td></td>
<td>Shared Decision-Making</td>
<td></td>
</tr>
<tr>
<td>I stay as well as I can</td>
<td>Maintaining Identity</td>
<td>Continuity</td>
</tr>
<tr>
<td></td>
<td>Improving Health &amp; Healthcare</td>
<td>Achievement</td>
</tr>
<tr>
<td>I live life as I want</td>
<td>Maintaining Identity</td>
<td>Continuity</td>
</tr>
<tr>
<td></td>
<td>Shared Decision-Making</td>
<td>Purpose</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Achievement</td>
</tr>
<tr>
<td>I have things to do</td>
<td>Maintaining Identity</td>
<td>Continuity</td>
</tr>
<tr>
<td></td>
<td>Shared Decision-Making</td>
<td>Purpose</td>
</tr>
<tr>
<td></td>
<td>Creating Community</td>
<td>Achievement</td>
</tr>
<tr>
<td>I belong to a community</td>
<td>Creating Community</td>
<td>Security</td>
</tr>
<tr>
<td></td>
<td>Maintaining Identity</td>
<td>Belonging</td>
</tr>
<tr>
<td></td>
<td>Shared Decision-Making</td>
<td>Continuity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Purpose</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Achievement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Significance</td>
</tr>
</tbody>
</table>

### Process Outcomes:

<table>
<thead>
<tr>
<th>Talking Points Outcome Domain</th>
<th>My Home Life Theme(s)</th>
<th>Senses</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can trust staff and rely on them to respond</td>
<td>Maintaining Identity</td>
<td>Security</td>
</tr>
<tr>
<td>I am supported to live well and plan for a good end of life</td>
<td>Shared Decision-Making</td>
<td>Security</td>
</tr>
<tr>
<td></td>
<td>Supporting Good End of Life</td>
<td>Significance</td>
</tr>
<tr>
<td>I have a say in decisions about my care</td>
<td>Shared Decision-Making</td>
<td>Security</td>
</tr>
<tr>
<td>My family and friends are involved if I want</td>
<td>Maintaining Identity</td>
<td>Security</td>
</tr>
<tr>
<td></td>
<td>Shared Decision-Making</td>
<td>Continuity</td>
</tr>
<tr>
<td>My privacy is respected</td>
<td>Maintaining Identity</td>
<td>Security</td>
</tr>
<tr>
<td></td>
<td>Shared Decision-Making</td>
<td>Significance</td>
</tr>
<tr>
<td>I am listened to</td>
<td>Maintaining Identity</td>
<td>Security</td>
</tr>
<tr>
<td></td>
<td>Shared Decision-Making</td>
<td>Significance</td>
</tr>
<tr>
<td>I am treated as an individual</td>
<td>Maintaining Identity</td>
<td>Belonging</td>
</tr>
<tr>
<td>I am valued and treated with respect</td>
<td>Maintaining Identity</td>
<td>Belonging</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Significance</td>
</tr>
<tr>
<td>Change Outcomes:</td>
<td></td>
<td></td>
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<tr>
<td>---------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Talking Points Outcome Domain</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have settled in to where I am living</td>
<td></td>
<td></td>
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<tr>
<td>My confidence / morale is improved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My physical / emotional health has improved or my symptoms reduced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My skills are improved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My mobility is improved</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>My Home Life Theme(s)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing Transitions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing Transitions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving Health &amp; Healthcare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing Transitions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving Health &amp; Healthcare</td>
<td></td>
<td></td>
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<tr>
<td><strong>Senses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Belonging</td>
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<tr>
<td>Continuity</td>
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</tr>
<tr>
<td>Security</td>
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<tr>
<td>Continuity</td>
<td></td>
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<tr>
<td>Achievement</td>
<td></td>
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<tr>
<td>Security</td>
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<td></td>
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<tr>
<td>Continuity</td>
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<tr>
<td>Achievement</td>
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<tr>
<td><strong>Continuity</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Achievement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Achievement</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Care Homes selected for the study

Three Care Homes were selected by the Local Authority to participate in the study, they were involved between January-April 2014.

<table>
<thead>
<tr>
<th>Name of Home</th>
<th>Number of residents</th>
<th>Number of staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Home A</td>
<td>32</td>
<td>44</td>
</tr>
<tr>
<td>Care Home B</td>
<td>34</td>
<td>43</td>
</tr>
<tr>
<td>Care Home C</td>
<td>37</td>
<td>43</td>
</tr>
</tbody>
</table>

A brief overview of each care home is presented below.

**Overview of care Homes**

**Care Home A**

Care home A has 32 beds, with 1 respite bed and 1 intermediate care bed as part of a pilot. It also has a Day Care facility which has places for 22 service users per day. Despite the narrow corridors and a very cramped, small entrance hallway, it has a pleasant, friendly ambience. There are pleasant, good sized sitting and dining areas for residents to spend the day together if they choose to do so. The bedrooms are small and do not have en-suite facilities; residents have to share toileting and bathing facilities. Residents’ names are sellotaped to the door of their room. All of the communal rooms and bathrooms have both pictorial and words signs to describe their function. There are a plethora of other notices and signs around the home either to encourage staff compliance e.g. keep this door locked or with information to attract visitors and staff to notice.
Staff appear to be happy and seemed very busy with helping residents with daily living activities and there was little evidence of other activity between meals. The TV was on in all communal areas which some of the residents seemed to be watching. Residents can choose where they spend the day and some spend it in their rooms, whilst others come together in the sitting room. All are encouraged to eat together in the dining room.

Evident in many areas of the home was memorabilia of the heritage of the local area. There is a pleasant outside garden area in the middle of the home which is clearly used well in the summer time.

The Manager’s office is small and cramped; there is a further, larger office for staff to write notes and hold meetings. The staff room is small and has very little in terms of facilities for staff to eat and relax in their breaks. There is only one communal staff toilet.

Care Home B
Care Home B has 34 residents who live in 4 separate smaller units, 3 on the ground floor and 1 upstairs. It has a nice and relaxed atmosphere with a ‘bit of a buz’ about the place. There is a nice large open hallway with seating areas where the residents can sit and watch the world go by, rather than sitting in the communal living area space.

Although the corridors are narrow, there are small alcoves with pleasant seats and sofas for residents either to have rest if they are walking to and fro, or if they choose to sit in a quieter space. There was little evidence of mirrors in the hallways. Residents can choose where they spend the day and some spend it in their rooms, whilst others come together in the sitting room. All are encouraged to eat together in the dining room. Many residents are unable to move without assistance, whilst others can move around.

Bedrooms are small and there are no TV points in the rooms; some have en-suite facilities, but not all with residents sharing bathing and toileting facilities. There is a room which is designated for smokers which is appreciated.

The manager’s office is small and has recently been fitted with new work surfaces. There is a larger office for staff to gather and small ‘cupboards’ within the units where care plans are kept and staff can write their notes. The staff room used for their breaks is at the back of the home and is a cramped environment looking onto the ‘bin’ area. Although there is a TV there, it is only used for training and the microwave was removed as nobody was taking responsibility for cleaning it. There is only one communal staff toilet.

There is a pleasant outside slabbed space which has bird tables and plants in tubs and is used well in the summer for BBQs and sitting in the fresh air.

Care Home C
Care Home C is home for 35 residents, 2 of whom are in for respite care. It is subdivided into 4 small units named after local places and Scottish towns. Each of the smaller units has a kitchen area where staff and relatives can make drinks as well as their own sitting and dining areas. The TV is the main focus for entertaining residents in the sitting rooms. Corridors are narrow and there are few places for residents who like to be on the move to rest, other than in the hallway where there are seats for them to stop and watch what is going on, not
necessarily choosing to take part in anything planned or structured activity, just enjoying watching and engaging with staff, residents and visitors on a social level. The radio is on in the hallway.

There is a large open hallway with staff offices opening from it. The manager’s office is small and has no window. The staff office is a bright larger room beside the front door and has recently been re-furbished to provide more work surfaces.

The staff room is bright and pleasant with a table and chairs and is the largest of the staff rooms in all of the homes. There is a staff fridge and microwave and male/female toilets.

There is evidence of signage to help residents locate toilets and the communal spaces. Recently staff have been involved in helping residents with ‘meaningful activities’. This is helping them to understand that assisting residents choose their clothes or jewellery for example, is meaningful and is attending to them as a person, maintaining their identity. This is as important as engaging with them in other activities like bingo and quizzes. There is a small enclosed pleasant outside garden which is slabbed that is used in the summer time.

**General observations**

In all of the homes, the care support workers were also employed to work as domestics which the staff find very challenging. Without exception, staff expressed a desire to have these roles separated so that they can be clear about their role in the home.

Time is a huge issue for staff and there is often not time to put an activities programme in place with staff speaking about the lack of time to do anything other than helping residents with activities of daily living. None of the homes has an activity co-ordinator. Staff spoken to as part of the study were committed to their jobs and felt proud that they were employed in a caring role.

There can be tensions for staff between providing an environment which is as safe and homely as possible and also one that complies with the many legislations and scrutiny the environment is subjected to. This might account for the many notices observed around the homes.

These homes will close in time and residents and staff will move to the new care homes. Staff, relatives and residents know that this is the plan for their future and were interested in taking part in the study.
Methodology
The study was designed to illicit the experiences of residents, staff and families to inform the design of the new homes to be built by West Dunbartonshire Local Authority.

Method Choice
As the purpose of this work was to inform the design of the new care homes, it was recognised that possibilities for alternative and more hopeful tomorrows can become clouded by taken-for-granted assumptions and moulded preferences anchored to current realities. The data collection therefore drew upon principles of Appreciative Inquiry, which gives permission first to take the time to discover what’s working well and is valued, and then to dream about what might be.

People may however lack the vocabulary, particularly the emotional vocabulary to give voice to their inner thoughts and feelings. They may also need encouragement and support to reignite their imaginations. The potential of older people in particular as a creative and active resource can be realised through more innovative methodologies and offering a variety of flexible methods. The use of methods such as collage work and collective writing, emotional touchpoints and photo language can enable people with diverse capabilities to express their views in different ways, and in themselves provide opportunities for enjoyable interaction.

Data Collection
The researchers spent a total of 9 days gathering data, 3 days in each of the 3 selected care homes. A number of methods were utilised to collect meaningful data. Specifically the researchers used the following techniques:-

Observation
Observation of activity, relationships and environment in 3 care homes. This was carried out to capture cultural components of life in the care home that are not necessarily easily articulated. Specific observations will be described later within the report.

Emotional Touchpoint Stories
Emotional touchpoint stories were facilitated with residents, family members and staff members in each of the 3 care homes. Particular touchpoints included – being part of the community, coming in and out of the home, having things to do, talking to staff, visiting the home, talking to residents and relatives, talking to staff, and involved in decision making. The method focuses on emotion by asking patients and their families to think about key points in the care journey and to select from a range of emotional words those that best describes how they felt about an experience (Dewar et al 2010). Participants were asked to pick from a range of emotional words to sum up how this feels for them in their current environment. The benefits of using this approach include its ability to help people to see in a more balanced way both the positive and negative aspects of an experience, and to help service users to take part in a meaningful and realistic way in developing the service (Dewar et al 2010).
Example of an Emotional Touchpoint

In total, the number of participants who provided Emotional Touchpoint stories was n=40. They collectively provided 37 Emotional Touchpoint stories. The data from the stories was analysed and the findings are described later in the report. Details of who provided the stories and the touchpoints they spoke about are illustrated below:

<table>
<thead>
<tr>
<th>Home</th>
<th>Participants</th>
<th>Emotional Touchpoints selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Home C Day</td>
<td>4 service users</td>
<td>Attending the Day Centre</td>
</tr>
<tr>
<td>Care Centre</td>
<td>2 staff</td>
<td>Involved in decisions</td>
</tr>
<tr>
<td>Care Home C</td>
<td>6 relatives</td>
<td>Care for your relative x3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Visiting the home x 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moving in and out of the home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Involved in decisions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Having things to do</td>
</tr>
<tr>
<td></td>
<td>3 Residents</td>
<td>Having things to do</td>
</tr>
<tr>
<td></td>
<td>5 staff</td>
<td>Coming to work</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Being part of a community x2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Meeting with staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>My space/work environment</td>
</tr>
<tr>
<td>Care Home A</td>
<td>7 Relatives</td>
<td>Visiting the home x 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Involved in decisions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Getting information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Having things to do x 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moving in and out of the home x2</td>
</tr>
<tr>
<td></td>
<td>4 Residents</td>
<td>Having things to do</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Living in a nice place</td>
</tr>
<tr>
<td></td>
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<td>Being involved in decisions</td>
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Focus Groups and Collage work

Group discussions with a wide range of stakeholders using creative strategies to encourage thinking out of the box e.g. use of collage. These discussions would focus on the ‘dream’ care environment. A total of 9 focused discussions were held with staff, residents and families where the focus of the discussion was ‘what matters to you about the new home?’ Findings of the discussion groups and the collages created are described later in the report.

Photo language

Photo language was used in particular with those residents who have a cognitive impairment – images can help them to articulate thoughts and feelings about a range of concepts. Photographs can also help people to communicate intangible aspects of culture and to bring out emotions associated with the phenomena under study that may remain hidden with verbal interview (Dewar 2012). The researchers asked staff, residents and families to select photos which helped them describe what matters to them about the new home. Findings from this work will be described later in the report. A total of 54 people were invited to select images and they chose 75 images to help them describe their thoughts and feelings around their current home and their aspirations for the new home.

### Breakdown of numbers of Images picked by residents, relatives and staff

<table>
<thead>
<tr>
<th>Number of Participants</th>
<th>Number of Images selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents 14</td>
<td>19</td>
</tr>
<tr>
<td>Relatives 21</td>
<td>22</td>
</tr>
<tr>
<td>Staff 18</td>
<td>34</td>
</tr>
<tr>
<td><strong>Totals 54</strong></td>
<td><strong>75</strong></td>
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Feedback
Where possible the MHL facilitator worked with the Care Home Manager. When this was not possible, detailed feedback on the findings were provided in order to inform others of the work undertaken.

Data Analysis
A thematic analysis of the data collected through the various methods was conducted. The analysis was primarily concept-driven, making use of the purposefully created conceptual framework that synthesises the *Talking Points Outcomes for Older People Living in Care Homes*, the *My Home Life* themes and the *Senses framework*. While this provided a clear evidence-based structure to guide the analysis, there was sufficient space within the approach to discover and explain other unexpected aspects of the participants’ experience. Indeed, a number of additional themes emerged from the data, particularly with regard to aspects of the physical environment and distinctive spaces.

Ethics
Ethical principles were adhered to in this study. All staff were given information about the purpose of the study before any data collection commenced. Staff were approached and asked if they would like to participate, they were also asked to identify residents and relatives. These relatives and residents were then given information about the purpose of the study and asked if they would like to participate. It was explained that confidentiality and anonymity would be respected, that they could choose to participate in as little of as much of the data collection as they wished and that if they chose to withdraw there would be no pressure put on them to continue. The researchers were attentive to the emotional aspects of the study and if there were any signs, either verbal or non-verbal, that the participant wanted to terminate any aspect of data collection this was respected. Consent was an ongoing process of continually checking out the participants wished to continue to be involved.

All participants were given a copy of their stories to check for accuracy, and asked whether or not they were happy for their story to be included in the final report. Observation data was discussed with staff for agreement to include in the report. It was explained that no names of either the individuals or care homes would be used in the report. If they were happy to share their stories anonymously they signed a consent form agreeing to do so.
Findings

Discovering What’s Working Well via TouchPoint Stories and Observation

5 residents, 5 family members and 5 staff members in each of the 3 care homes took part in the touch point work. Particular touchpoints included – being part of the community, going outside, having things to do, talking to staff, having visitors, talking to residents and relatives, talking to staff, being part of a community. Participants were asked to pick from a range of positive and less positive emotional words to sum up how this feels.

The findings were themed using the 8 My Home Life themes, with sub-themes identified to convey the contextualised and nuanced accounts within each. Links to the Senses Framework and to the Talking Points Outcomes for Older People Living in Care Homes were also highlighted where appropriate.

My Home Life Theme 1: Maintaining Identity

Knowing the resident

Staff valued knowing something about the person to help maintain people’s identity.

...I feel good about myself and when I help people. Having a conversation and doing their nails. Finding out what matters to them and then helping them do that. Reading their care plans and getting to know them. Finding out what they used to do. (DS 26 staff)

Personal possessions in resident’s rooms would invite conversations about who they were as people. Regular conversations with relatives also helped them to understand the resident as a person particularly where there were cognitive difficulties.

Staff found out about residents through conversations and observations. This took time. This information tended to be recorded in care plans. However the care plans were not in the resident’s room – these were in an office. It seemed hard for people to access this information on a regular basis. The information that was prioritised to be visible to all tended to be of a clinical nature or a warning e.g. falls risk.

Relatives particularly valued knowing the little things that mattered to people, as revealed in quotes:

If I did do anything, like tidying out her drawers. Mum likes them nicely folded. But I feel I wonder how they (staff) would feel when things look different (DS16 relative)

It was uncertain if staff always knew details such as ‘likes clothes nicely folded’, which are at the heart of the Talking Points outcome I am treated as an individual. From an examination of documentation it did not seem that this type of information was detailed in the care plan.
Rather, the care plan seemed to focus more readily on how residents liked to sleep, likes and dislikes in relation to food, and activities they enjoyed.

Through the processes used in this project we were able to find out additional information about the residents as people – for example using images to ask what mattered to them. It may be that greater attention needs to be given to the use of range of ways to elicit and share information of this kind.

**Knowing the relatives-knowing the staff**

Knowledge of the person was also important for relatives and staff.

*When I can't come in I wonder what the staff are feeling about me. But they don't feel like that. They appreciate and respect me.* (relative DS10)

*When I am not well they know cos I tell them. Normally they'll phone me and tell me not to worry. They give me permission not to come in when I am struggling. They know me well.* (relative DS10)

Knowing the relatives and what is going on for them was important in maintaining identity and developing relationships.

*I’m friendly and I chat with the staff. They ask me about things I am doing and they tell me things that they are saying. If staff are new I would introduce myself to them. Some of them don't wear name badges which bugs me. It’s nice to be able to call the staff by name. We can open up to them when we get to know them.* (relative DS12)

Staff also recognised that sharing something about themselves as a person was valuable:

*I am going to be a key worker. I hope they (relatives) would be able to come and speak to me and trust me. Building up a good relationship with them. Being able to tell them about me. My family and what I like to do.* (DS 26 staff)

**Having your own things**

Residents valued being able to personalise their space and in all homes were able to do this to a certain extent. For example some residents brought in their own bed, other furniture, pictures, or a favourite chair. There were however limitations to this depending on the size of the room. Having personal possessions was important to residents and families and there was frustration and upset if this was compromised in any way:

*Own furniture, own towels Own bedding
I had to put a sign in her room to say that it has to be ironed
She keeps getting things that don’t belong to her despite her name. Name on everything. Laundry needs to be organised.* (relative DS12)
I had 15 pairs of pants and I only have 9 now. You don't get your stuff back. They're not ironed. I was down to one nightdress. One of them wasn't mine. They're big things to me when I was in the habit of being dress conscious..and sometimes my bras are filthy when they come back. My daughter marks them all but that doesn't help. Don't want to cause ill feeling but I like my own clothes. If they sorted it with me that would help. I've offered to go the laundry and help sorting. Makes a difference when it works well. You're congratulating them and you feel great! Sometimes they tell me to just put it on. You have to get on with and make the most of it. (DS 19 resident)

Having the wrong things was often seen as a breach of identity and could be quite frustrating and upsetting for people.

There were numerous comments about the inadequacy of the laundry system across all homes. More creative thought needs to go into how to address this problem as this has a significant impact on identity.

**Too old to do what we used to do**

Many of the residents were incredibly frail with complex needs, and varying degrees of sensory and cognitive impairment. There was a sadness and a sense of loss in their conversations where they felt no longer able to enjoy doing the things they used to do. Staff often found it difficult in learning about who the resident was as a person, and what they liked to do and feeling the need to rekindle and maintain this interest.

*No work in here, but it's a long day. Would like to go swimming but I'm too old.* … (resident DS1)

*I'm getting fed up just sitting around doing nothing. I used to do sewing and knitting but I'm not able to do it now and it's a much bigger job doing things now. I don’t hear and see the TV. Folk roundabout don’t hear you and I don’t hear them. It’s very difficult.* (DS21 resident)

It was not always about being too old or too frail to do things, it was also about lack of motivation.

*I used to bake and sew but not now, I can’t be bothered now. Occasionally I take part in activities but I find it tiring. Last week they brought animals in. They sat on my lap for a while. I’ve lived for too long. I miss my pals, they’re all away and it’s lonely sometimes. I have a very good neighbour and she visits.* (resident DS1)

*I used to read and now I can't be bothered.* (Resident DS7)

Quite a lot of effort was put into asking residents about hobbies or what people used to like doing and then trying to do this again. Staff and relatives would become quite disheartened when they tried to organise things they felt mattered to residents and then people did not participate, detracting from their senses of purpose and achievement.
They have virtually no stimulation here at all. They're all just sitting there. TV is either too loud or too low. She’s looking at four walls. When something is organised, she doesn’t always want to do it. (relative DS12)

Relatives also commented on their ability to maintain their own identity and relationships with the resident as they also felt ‘too old’.

Sometimes I would like to get involved in the care, but I’m not physically able to do so anymore. I’m sad about that but I was trying to help and I’m not able (relative DS10)

This is a complex area that gets to the heart of the changes that accompany ageing towards the end of life, and is expanded upon in the theme below.

Having things to do – It’s not always about doing something

In all of the homes there were structured activities which, in the main, seemed to work well but efforts were often hampered by staff having a lack of time to devote to this. In some cases activity was the responsibility of one person and when they were not on duty activity did not necessarily happen:

When something is on, entertainment come in sometime. Nan and Eddie come in and they're good. Sometimes they put things on that we don’t like eg quizzes so I don't go all the time. It’s good to learn and gets the brain working. Bill was good but since he’s been off so nothing happens. (DS19 resident).

From discussions there appeared to be low expectations on the part of residents and relatives about what was possible within the context of community living in a care home:

She used to go the tea dance at the church. I keep saying do you want to go back, but she doesn't want to bother the staff. (DS15 relative).

I’m a Celtic supporter. John used to take me. I would love to go again. That would be my dream. I miss going up to Parkhead. We can’t watch it, because we don’t have Sky. Used to run two boys football team, and give advice (DS19 resident)

There did seem to be an emphasis on ‘doing something’ as being one of the key aspects of maintaining identity. This was not only raised by staff but relatives too:

Alive they are alive. This is not a hospice but if there is nothing for them to do then it brings them down. They have hearts and feelings. They’re left to sit. Silence. Too much silence. Not enough exercise. No dominoes etc. Staff need a connection with them. (DS 30 relative)

However other quotes referred to being in the moment with the resident and maintaining identity through noticing what they were currently enjoying, talking about, thinking and sensing.
Sometimes he lies and thinks about things...he’s got time to think and reflect now. Sometimes sad and sometimes a bit high. (relative DS 10)

The simple life. Elderly people in general just want a simple life. Sometimes we think they need this and that and sometimes all they need is a good blether, and a good laugh. (relative DS12)

Nice to see the sun melting the snow. Nice to see outside. You can go out if the family are with you. If you didn't have any family maybe the staff would take them out. A wee break is nice (resident DS7)

We like watching the weepy movies. I like crying. We still have emotions and feelings. We can have a conversation with each other. Some of them can’t converse I feel sorry for them. It would be nice to do things together (DS 19 Resident)

Finding ways to help people to express emotions and feelings was also important. It can be more difficult however to evidence and share the outcomes of conversations, moments for reflection, and enjoying seeing the sun melt the snow.

**Having a sense of purpose**

Doing something that could lead to a sense of purpose was important for some people.

I don’t talk to others, they might think I am being nosy. .... I could set the table or fold napkins. I like to have something to do. (DS 21 resident)

No work to do. Everything is done for me. I used to do gardening or sit in the garden when the sun is out. The sun is better than any medicine. I like my bed to be aired. (Resident DS7)

Some residents liked the fact that many things were done for them and there was minimal responsibility.

We can make an appointment to get our hair done, that’s nice, no responsibility, it’s very nice.

A relative also spoke about the fact that she valued everything been done for her:

I’m relieved that I am not having to run after mum. Just knowing she is being looked after and I don't have to do anything. Sometimes I don't know if I should be doing anything . I feel as though I might stand on somebody toes. (DS16 relative)

In the quote above the relative is uncertain about what she can or can’t do to have a sense of purpose. This relative knew what mattered to her mum and was trying to carry this on but felt uncertain if she could do this for fear of upsetting staff. Relatives often made a decision not to say anything as they were so grateful that their loved one was in a safe
environment. The safe environment was something that relatives valued over and above other aspects of care.

Another relative spoke about how much she valued continuing her caring role and having something to do:

*She is settled and comfortable in here, I feel comfortable coming in. I know they would call me if there was anything else. I still feel part of what’s going on. I just join in with what’s happening on in the room with the other residents and then I take her to her room and put her cream on her legs. And do her hair. I wouldn’t like to just sit in her room when I visit. They all join in.* (relative DS9)

In order to achieve a sense of purpose residents did talk about wanting to continue daily routines they used to do at home but recognised the restrictions of home life.

*It’s nice to have the meals made for you but you feel you should be at home doing it yourself. Used to make my own meals, but we’re not allowed in the kitchen. Used to sit with my food on my lap watching the telly. I always sit at the same table. I was told to sit here.* (DS 13 resident)

There was some evidence in the data that described where staff had worked to achieve a sense of purpose and achievement for residents and balance associated risks. For example in some homes residents were able to go into the kitchen, and fold napkins and set the tables. Staff did discuss frustrations with trying to achieve this for residents because of the restrictions they felt were imposed on them by health and safety and infection control policies.

**Trying out things we’ve never done**

There was an emphasis on trying to maintain activities residents used to enjoy however some residents made reference to participating in and enjoying things they had not done before:

*When I won the bingo prize I’d never done bingo before. But it was good....I just got a sweetie, but it was good, I quite liked it! We’re easy pleased, Music. Dancing. Foxtrot. Do you like dancing? If nobody is about.* (Resident DS7)

There was perhaps an element of surprise that something new could be enjoyable.

*Were just sitting about. It’s a long day and on the better days we can sit out in the garden. We can get a tan! When you feel fed up and I would like something to do. We’re not allowed to do some things like setting tables, It’s ok to try things that we have never done* (DS19 resident)
It may be that having caring conversations to find out what matters to the person now and in this setting, as well as noticing things that enhance people’s well-being may encourage different opportunities for living a life full of possibility and potential in a care home.

My Home Life Theme 2: Shared Decision Making

It is well recognised that all stakeholders, residents, relatives and staff can have an important contribution to make to the ‘life’ in a care home and that shared decision-making is important at a number of different levels. The degree to which people can be involved in shared decision-making within care homes depends on the relationships that people have.

Having a voice

The ways and extent to which people were included in decision-making varies. It seemed important to have the space and a feeling of safety for everyone to be able to articulate their opinions and ideas.

For example, for staff there appeared to be a tension between what staff talk about outside of a meeting and what actually happens during a meeting because of feeling awkward and embarrassed.

*Sometimes everybody has opinions, and sometimes it’s only one person that talks...outside of the meeting and then nobody talks. They all say nothing. It makes me feel frustrated and uncomfortable. I will say something. It can be awkward. ...We don’t have to agree. I wish I knew how to help people speak. They sometimes don’t want their name to go against something. Some people are embarrassed.* (Staff DS4)

There was some evidence from staff that they recognised that many decisions were made by their managers, but they believed that they had a right to have an opinion. Finding a way to express this tension was seen as more positive and healthier than its suppression.

*Being positive. No point in worrying about things you can’t control like management decisions and we are brought into them. A lot of decisions are made by management. Go and speak it out, don’t keep it inside. Lisa is approachable. Don’t let something go sour.* (DS20 staff)

In relation to some decisions, there was evidence to suggest that residents did not always feel able to express their opinions to staff, or were not asked for their opinion by staff; instead residents expressed views to their relatives, which could then prove challenging for relatives to take forward.

*She’s not very happy with the food. Always big chunks of chicken or meat. She likes it cut thin and presented nicely. Only gets one choice. Mushy peas...she hates them, they don’t ask her. She wouldn’t say to the staff but she says it to me. She’s not getting what she wants. I would like to see her getting more choice. She’s as sharp as a tack and knows what she wants.* (DS15 relative)
There were however also many examples where relatives talked about being able to have a voice and be heard.

*At the annual review we go through her care plan with me; my brother and sister come as well. They ask are we happy with her care, they're interested in what I think. They really do care about my opinion. They take heed of what I am saying* (DS14 Relative)

**Feeling included**

Generally the data revealed a high level of relative involvement in terms of decision-making, including both large and small decisions, which was highly appreciated. The fact that staff listened, were interested in what relatives thought, and acted on things was valued. One relative felt ‘on an equal footing’ with staff and that her involvement was as important as that of the staff.

*If there are any decisions to be made about my mum, they would involve me. They involve me in everything, new clothes, the doctor...they'll phone me every time.*

*I feel respected. They ask how I am and give you your place as far as updates go. I feel on an equal footing.* (DS10 relative)

*My thoughts would be respected. They would not brush me off, they would listen.* (DS14 relative)

Relatives also appreciated when staff asked for their expertise and help with their loved one when they were experiencing challenges in supporting the resident with activities of daily living.

*They spontaneously tell us about her. Sometimes Margaret does not allow them to dress or bath her and they ask for our help.* (DS 23 relative)

The relationship between staff and relatives seemed to be key in terms of relatives being supported in decision-making. Staff being approachable and available supported relatives to discuss issues.

*If I had to make a decision then it would be supported. About anything. I believe I would supported. I feel comfortable with the staff. They are always approachable, they always acknowledge me. I wouldn't think twice about approaching them. I think they have a great work ethic.* (DS14 relative)

There were sometimes differing views about who had the most knowledge about the resident now that they were living in the care home. This could have an effect on decision-making. Staff believed that relatives knew their loved one better than they did and therefore would include them in decisions rather than be seen to be ‘taking over’; however, there were times when the relatives believed that staff actually knew more about their loved one now and were happy for them to make the decisions on their behalf which they respected.
The family know their relative better than us. (Staff DS8)

I want to make them feel included and not feel we are taking over. (Staff DS8)

I would rather the staff were involved in decisions – they know things we don’t. I believe that staff have a right and a duty to make decisions. I respect their input. (relative DS8)

When staff were involved and supported in decision-making about residents it was highly valued.

It feels good. When we make a decision about the clients and then you’re supported in the decision. I feel good when any decision has to be run past the team. (DS 20 staff)

Sometimes the perceived lack of control could also be upsetting for relatives when they had tried, in their way, to make a decision that was then ‘over-ruled’ for some reason. This underlines how important effective communication is in relation to decision-making.

Because I don’t have the control over what’s happening. It’s hard to describe. I left everything out for Christmas and she had an entirely different outfit on when I came in, so I just changed her. I felt that day it didn’t matter to them what she wore. I didn’t say anything I just changed her. If we had had the conversation the night before it might never have happened. (DS16 relative)

Keeping staff in the loop about what was going on within the home in order for them to express their opinions could also be challenging and could lead to a sense of feeling devalued. Fora to be able to hear information and plans for the new home as they emerge and to discuss these with staff would be valued:

I feel I have not had the recognition of the work I have done. No praise I just feel there is a culture of......a clique birds of a feather flock together. So lots of information is second hand and comes through in a different channel. Why does that person have information that I don’t have? We’ve not been taken along with other parts of the service. Recognition and value is about being included and being involved in decisions that affect you. (staffDS6)

I feel anxious about the move. .... Not sure how it’s going to work out. What would help? Just having an opportunity to say it. Provide as much information as we can would help. Maybe provide meetings for staff where feelings are explored. (Staff DS3)

What’s allowed and what’s not allowed

Shared-decision making was not just about people coming together to make decisions based on different perspectives. There were certain ‘rules’ to be followed, often imposed by policies and regulatory requirements.

I’ve got football things in my room, programmes of the games etc..all the Celtic stuff. Got a nice bedroom, canny complain. ..... I would like my things on the wall but I’m not allowed to do that. (DS 19 resident)
In the situation above the gentleman was not allowed to have his ‘things’ on the wall as it would mean placing them above a radiator.

Sometimes lack of staff time dictated whether or not a resident could choose, for example, to have a bath when they wanted. Also, with reference to the quote below, the resident had an infected toe and staff were worried that this might be hazardous to other residents because of the shared bathing facilities.

*If I ask for a bath they say they are too busy. No time. They said they couldn’t cos there might be an infection.* (DS19 resident)

**Making compromises in decision-making**

Current policy emphasises voice, choice and control, but this can be problematic when different individuals have different perspectives, what’s desires is not possible and ultimately compromises have to be made. Compromises can be confusing and challenging for all.

The quote below demonstrates this dissonance where the resident was expressing a desire to go out, but the relative decided they were not, and the consequent sadness and upset for both:

*She has her hat and coat ready to go out and when I tell her we are not going out she goes in the huff with me. I have a heavy heart when I come in sometimes. She doesn’t want anybody but me.* (DS16 Relative)

Similarly, in the quote below the staff member is debating the need a resident has to be surrounded by personal possessions, but concurrently acknowledging the health and safety issue for both staff and the resident:

*Some of the residents’ rooms are small. Some residents will not part with anything in their room. It can be a health and safety issue for staff as well as the residents.* (DS 25 staff)

The Talking Points personal outcomes approach is grounded in expectations that negotiation and compromise will often be necessary, based on a clear understanding of what matters and why. Often residents will accept compromises providing that key process outcomes, grounded in supportive relationships, are met, notably *I feel listened to* and *I am valued and treated with respect*.

However, space in general can be logistically challenging for all within current environments that are often not fit for purpose. Staff are challenged by the lack of space for equipment and the positioning of items for clinical waste, which can compromise the safety and the overall experience for residents. Feeling unable to do anything about this is frustrating and staff are looking forward to the new home where there will be more space.
Toilets don’t have space for a zimmer. Yellow bins should be in a designated room or have a chute, not in the bathroom with a bath where residents are hoping to enjoy a pleasant bath. (DS 25 staff)

Sometime when I go through the back to get wheelchairs everything is rammed in. Scales, hoists, wheelchairs. It’s the only place to store. It would be better if we had somewhere proper to store things. (DS 25 staff)

Theme 3: Creating Community

Seeing people

Most residents did enjoy seeing people and being around people in the care home:

It’s better than living at home cos I have not got such work to do in here. No, it’s very peaceful, nice to have people around you, you’ve got the telly...I think we are perfect and peaceful. Company is good, food is lovely. I feel fine I’m not able to do things that I used to do now. I am 94 and had 5 of a family. On the whole were all happy here...no grumbles at all we try and help each other. I like the company and the girls. It’s a well-liked place. (Resident DS1)

They are good. Got company in here, well looked after. Can’t come and go as you please. Would like that. Used to go to mass and priest comes once a month. Would be nice to have a service on a Sunday (Resident DS1)

Staff identified some of the challenges associated with maintaining people’s own space within the community of the care home:

The residents are all in units and if they go into another unit all hell is let loose. I feel they don’t really mix unless we have a social evening. The environment used to be different, and it was easy to manage. Sometimes they like to be on their own. (Staff DS4)

Although seeing people was valued by some, this had to be balanced out with the need to check preferences out with people, as being on one’s own was also valued.

Some people assumed that residents would want to make new friends in the care home. Specific interventions like taking people to sit in the sitting room and having tables that seat a number of people in the dining room emphasised being together rather than being apart. Although in all of the homes staying in your own room was permitted – it did mean that those who wanted to be on their own had less choice about where they could be.

I go to my room a lot. I play music and play my keyboard. I do puzzles and I read. There’s a library here and I just go and pick one. If I could hear I would stay in the lounge, but I get the message. Some of them here are not exactly a bundle of laugh, so I content myself and make the most of it... I miss my home. (DS13 resident)
One resident raised an interesting point about visiting, challenging assumptions that residents always welcomed visitors and raising questions about the residents’ control over who comes in and out of their community:

*Sometimes people come to visit and you can’t get rid of them. You don’t like to stop them coming because you like the company but sometimes I can’t be bothered. They say they’ll come in on or Tuesday or Wednesday and I go OMG!* (resident DS7)

These observations are consistent with the definition of the Talking Points outcome *I see people*, which recognises that individuals should have some choice over who they spend their time with in communal areas, who visits and when.

Balancing collective needs versus individual needs was at times challenging for staff. One resident expressed her frustration at the activity in communal areas, which again related to issues of space:

*TV is on the whole time. We have to watch the programmes other folk choose and I can’t hear it. I have my own TV in my room. I’ve got talking tapes from the library and council.* (DS 19 resident)

However, the spaces with care home offered a different interpretation of seeing people, which did not necessarily relate to engaging with people. Indeed, being in spaces where people were passing by was valued by many residents. In one home many residents sat around the front door enjoying observing the to-ing and fro-ing from the home to the outside world.

For many residents seeing people was more specific and related to seeing family:

*If you make a wish I’d wish my mother was here. I loved her. I’ve only got one son and he’s in Canada. I write letters and he phones every week. He was here recently.*

*I wish all my family were all back.* (Resident DS7)

Seeing family and friends was what was important to many residents and there was a sense of loss that their family were no longer there. This is again consistent with the Talking Points definition of *I see people*, which recognises that this outcome can encompass layers of meaning, from experiences of not being lonely, through companionship, friendship to mutual affection and ultimately love.

**Positive Visiting Experiences**

Seeing people was also in part dependent upon people visiting residents, and understanding the experiences and aspirations of visitors was also important. One relative talked about the challenges of visiting and how she strived to make this as positive an experience as she could:
Visiting can be hard going if we are just in by ourselves. We come as often as we can – a few times a week. If there are others here, like her boys, it is nice. I try to make it a good visit for us all. I will ring the boys up after they have been and thank them for coming.

Some days are worse than others. She can’t do a lot of things. We need to ask for help to get her into a wheelchair. I’m limited with what I can do with her – sometimes she is sore – she might be like that because she doesn’t want to do something.

I can feel powerless over the situation because there is nothing I can do. I try to make things as normal as possible. I’m powerless over her dementia. I try to talk about things from the past. She does not remember her husband but she remembers times in Ireland.

I think I need to learn how to do visiting better. We are told we can make a cup of tea. We do this – this is always something we would have done – part of our routine.

I also try to make it fun for the grandchildren when they come in so they want to come back. (Relative DS8)

This narrative highlights the complexity of striving to be a ‘good’ visitor. Being able to do things on a visit, and having others around were important.

Helping each other

The outcome I belong to a community often involves reciprocity and a mutuality in relationships. Being able to offer help to others can enhance a sense of significance for the person – that their contribution matters. Some relatives and residents talked about how important it was to help others, but that this did not always work out:

We try to help others, but sometimes they don’t want it, they don’t understand it. We try to help them with meals, try to encourage her but they give me dirty looks and tut at me and so I don’t do it anymore. (DS19 resident)

Sitting with Mary at the table I try to help ... It’s hard to explain. I like to do the right things. Not sure what the right thing is. I like to help people in here cos were all in here for a purpose. (DS19 resident)

Whose place is it anyway?

Generally staff viewed the environment as primarily serving the needs of the residents and respected this:

Dining room is used for training. Got to be careful because it is their (the residents) space. We’re here for them (DS21 staff).

Staff spaces were on the whole pleasant environments within the home, but there were some rules about the use of certain areas for breaks and how people should spend their breaks as the following quote illustrates:

There is a wee room at the back which they also use for training and so we can’t have staff breaks in there when training is on. There’s a TV in the room but it’s only for training. We’re
not allowed to use it, but it would be nice to be able to watch the TV on our breaks. There was a microwave, but nobody was cleaning it so it was removed. (DS 25 staff)

Staff did value creating community for each other, not just community for the residents who lived in the home:

Night shift have tea ready for us and you do that for them. At the handover people talk about what’s been going on. (DS 25 staff)

Whilst nobody would argue that the priority is to develop the environment to achieve the best possible experience for residents, a relational approach to care, as advocated in the My Home Life programme, would advocate that ‘everybody matters’ and that paying attention to enhancing the experiences of those who live and visit care homes is also important.

**A Place in the Community: Bringing the outside in**

Developing community feels like quite a complex activity when you read the quote below:

Make it inclusive, make it safe, bring the community in to you. It’s about passing by and noticing, not going to a clubhouse. Community has to have ownership of that. (Staff DS6)

This raises the question as to how might we best promote ownership of community in care homes. There were many examples in discussions of different community members coming to the care homes.

Residents did talk about the value of visitors from the community coming to see them:

In this place, it's nice to have things to do. The priest or minister comes every week. Nice to have a conversation. I tell him things I wouldn't tell others. (Resident DS7)

Staff expressed their vision for having other community members and services as a part of the care community:

Want to feel part of the community. The fact that you can invite folk in, from the nursery, school .... Schoolchildren doing a project on the war and school kids coming in to interact with the service users. You need space to do these things. We can set up our living room and we can also use the dining room to include residents. Bring in shopping experience here. Bring in the local businesses, it’s important that service users can buy clothes. (Staff DS6)

**A safe community**

The importance of feeling safe was expressed by many of the relatives:

The staff give words of encouragement to me – I like this. I feel safe. I remember when I used to put mum to bed when she was at home – it was the best part of the day – I felt safe that she was in bed for the night and she was not going to go anywhere. I know she is safe here. (Relative DS8)
I feel safe particularly at night. I can get a sleep. She was always falling. I always worried. That worry has been taken away. (DS 15 relative)

After she came in because of the way the staff are I can live my life the way I want to without worrying. (DS 17 relative)

There’s security here. She’s safe and won’t get out! There is always somebody around. That makes us feel better. (DS 18 relative)

Residents and staff also spoke of the importance of safety, although with different emphases between feeling safe, particularly emotionally and being kept safe from harm:

It feels safe. Staff help me. If I’m depressed you can go to them. They listen to me. Sometimes I keep it to myself. The place. You can lock your bedroom door at night. ... Staff are great. If you need staff they come when you press the buzzer (DS19 resident)

It is a safe home. It’s all alarmed. We would know if a resident got out it’s our responsibility if they get out. I know I am not going to get into trouble. (DS 25 Staff)

Two relatives spoke of the importance of bed rails for ensuring safety, but were informed that these could not be used:

Bed side rail brought in for the bed because mum used to feel safe with that. I asked about putting it on, but staff are not allowed to put it on because of health and safety (DS16 Relative)

These issues are challenging for all, especially where there is a need to balance risk versus choice in order for everyone to feel safe.

All in this together - Shared purpose

The ‘shared purpose’ was working together to help the resident to feel as safe and happy as possible. In achieving this purpose there was evidence that staff worked together with outside agencies and relative sand residents to achieve this:

I like doing the job I do – I feel happy – I might have challenges but I feel supported – I can ring NHS 24, doctors and the district nurses and they help us. I can lift the phone anytime. The family support us too. I know if someone is at the end stage of life – with the best will in the world you would want to sit with them so they are never alone – but this is hard – the families understand this and come in and support us. (Staff DS8)

Feeling a part of things

Staff made efforts to ensure that residents could be part of things if this was possible, consistent with the outcome I belong to a community:
His bed can’t leave the room. He’s in a chair occasionally but he’s more comfy in his bed. There was an Italian night and he joined in by proxy. They made him part of it, he wasn’t excluded. He had balloons and he had the meal. Staff did involve him but they felt restricted because he couldn’t come out of his bed. He was made part of it. Really important to try and include him. (Relative DS10)

Being able to speak out and have a voice was valued by staff and helped them to feel part of the community too:

Staff all talk, treat everybody the same. In some places you don’t have a say (DS 25 staff)

The meetings have changed they use to be a rammy, but the meetings are different now. Only one person speaks so I would feel ok to say something now. I used to think what’s the point? The new way breaks the ice. You pick more things up more. (DS 25 staff)

Theme 4: Managing Transitions

Coming into the home

For many of the families and residents spoken to, admission to the home was the result of a general decline and then a crisis, not necessarily an anticipatory choice. Families described their initial feeling of negativity and perceptions about how their loved one would feel, think and behave around the care home option and then described how the atmosphere of the home and the staff helped to alleviate these feelings, consistent with the outcome I have settled in to where I am living:

Mum had been living on her own, and she had been falling and was found behind the door. She went into hospital where she was well cared for. I felt sick I wasn’t sure what her reaction was going to be. We supported her at home. My brother and I were there when she came in. I thought she might have been crying and been upset. It must have been frightening for her to be on her own. We were shown around by Kate; we just turned up and my brother said to me he had a good feeling. (DS17 Relative)

Families described not knowing what to expect about Care Home life and were anxious about going back on their word in terms of promising that their loved one would not go into a home, but trying to balance that with their concerns about safety. Somebody else helping them make the decision was helpful as the quote below demonstrates:

It’s a new situation, we didn’t know what to expect. It was the unknown. Before she stayed in her flat in Clydebank. She had a Care package in situ but for the in between times we were worried about what was happening. The consultant said the time had come. We felt awful. We always said we would look after mum she would not go into a home. We were anxious about how she settled in it took her a long time she wanted to come home with me. (DS18 relative)

A positive choice
Knowing that previous circumstances have changed, like a spouse dying and the associated grief and difficulty to cope without another person helped to make the decision to come into care. This was not necessarily a negative choice. Indeed many residents and relatives talked about enhanced feelings of safety, company instead of loneliness, and feeling part of a community, consistent with the suite of Talking Points Quality of Life outcomes:

*When I lost my wife I couldn't cope. I like it in here and I get on with everybody. I didn't even know there was a sitting room to begin with. I was sitting in my room all the time. The staff can help you. They know me.* (DS19 resident)

Families noticed the difference that settling into a care home can have in their loved one e.g. eating better than ever, consistent with the outcome *I stay as well as I can*

*The night she came in it was her birthday and they knew we were coming. No smell in this place. That was very important. It was scrupulously clean. They showed us the room I have ever felt snubbed or dissatisfied by the staff. She's eating better than she ever did for years.* (DS23 relative)

Many were very positive about the care home

*We feel comfy here. I've picked my room. There is a smoking area.* (DS 23 relative)

Staff anticipating the arrival of a new resident and showing them around was seen as very important in helping with transition, as was the odourless environment.

Transitions for staff were also important. Staff also have to adjust when they move jobs or enter the care sector world. Feeling included and trusted helped staff with their transition.

*When I first came here I came from a private home. It was a big change. We are included and trusted in a family review* (DS20 staff)

Some residents took time to settle before they were comfortable. In the quote below, staff identified a strategy of praying with the resident and this helped her to settle. Whilst this strategy would not necessarily work for others, getting to know the residents and finding out what matters to them personally was important to discover and then communicate this to others for continuity.

*She is comfortable. She didn’t settle immediately. She would empty her wardrobe. Staff say a wee prayer with her and that settles her. Ann started it and now they all do it.* (DS 23 relative)

Taking the time to involve the resident and family in creating a space that is ‘how they want it’ was important, mapping to the outcome *I have a nice place to live:*

*Got used to it and know people. I’m comfortable in my own room. It’s decorated the way I want it. I have my own bed, it’s a bigger one and a dressing table. Got all the photos of the family* (DS 19 resident)

Theme 5: Improving Health and Healthcare
This section includes quotes that relate mainly to changes in wellbeing, consistent with the change outcomes my (emotional) health has improved and my confidence / morale has improved. It should be noted however that many of the themes in the quotes above, for example in maintaining identity, also relate to health and the outcome I stay as well as I can.

The wellbeing of the resident was expressed by many relatives as being of paramount importance. Staff reassurance at times of decreased wellbeing was valued:

\textit{Sometimes he had faecal impaction and had an enema. He also had a chest infection. He got better quickly but I was still nervous. I felt foolish. I was able to call anytime. (relative DS10)}

**The meaning of staying as well as I can**

Learning about what matters to the person to stay as well as they can was important. For the resident in the quote below – it was important that he was able to move around in bed himself without constantly asking for help. The solution of the monkey pole was not working. The resident had an idea about what might work:

\textit{I have a hospital bed, but I have nothing to hold on to pull myself up. I’ve got a monkey pole but I haven’t got the strength. I just wanted a rail. I’m embarrassed. I’m such an able person and I feel awful. (DS19 resident)}

This raises questions about what helps staff to have the confidence to explore outcomes with the resident and to try out a range of things to make this happen.

**Keeping me in the loop**

Keeping people informed about what was happening about medical decisions was valued by relatives:

\textit{They call me and keep me up to date. When she needs to see the doctor they call one. They keep me in the loop about her well-being. They couldn’t do anything any better (DS17 relative)}

**Wellbeing of everyone**

There was evidence that staff cared for relatives’ wellbeing as well as the wellbeing of residents:

\textit{I am really confident in the way they look after me as well (DS17 relative)}

**Theme 6: Supporting Good End of Life**

It was interesting that end of life was spoken about in different ways by the 3 different groups who participated in this study.
We had been discussing moving to the new care home with a group of residents and one gentleman spoke of what he saw himself doing in 10 years. Another relative responded to this by saying:

OMG I don’t want to stay here for 10 years. I want to go to heaven. When you’re older you think twice about meeting new friends. Some folk you get to know and you want them all your life, others not (Resident DS7)

This resident expressed her expectation about end of life and her comfort with this as a natural part of her life, consistent with the process outcome I am supported to live well and to plan for a good end of life.

For a relative the discussion of end of life was alarming:

When they spoke to me about end of life care I was alarmed because I wasn’t expecting it. He (staff) took me into the office…If he had said that there was nothing to worry about it and it’s about something we have to know about for the future I would have been prepared. (DS14 relative)

Not all staff felt comfortable with being with relatives and residents at the end of life:

If residents are dying I feel awkward about the family. If I have a relationship with the family that would help. (DS 26 staff)

The topic of end of life was perceived differently by different people. For the resident it was an expected outcome and something she felt ready for, for the relative it was alarming to consider this, and for the staff member it felt awkward to confront this topic with relatives. It is interesting to consider what support there is to open up conversations about end of life in this care setting. This issue is likely to be of growing importance as, given the policy drive for people to stay at home for as long as possible, one inevitable consequence of resident frailty on entering the home is that deaths become more frequent, with profound implications for fellow residents, visiting relatives and of course staff.
Theme 7: Keeping the workforce fit for purpose

Keeping the workforce fit for purpose seems to be more than just training and competence. It related to culture, relationships and being valued for what they do.

**Challenge of dual roles**
In all the homes visited Care Support Workers all have a dual role as carers and domestics which they found very challenging.

*Changing duties make me feel frustrated. The job has been pared down, less organisation and more hands on... No domestics anymore and we have to do the cleaning. On our remit to do light cleaning duties. (DS 20 staff)*

Staff in these roles would love to have a clear remit by separating the roles of domestic and care support work out

*Perfect harmony by providing clear roles for domestic and care support staff and having a Job description. (DS 31 staff)*

**Time to develop practice**
Staff acknowledged the importance of the many facets of their role; however they also felt very pressurised by time and felt that sometimes they were not doing their jobs as well as they wanted to.

*I feel anxious when you're overloaded with work. You can't do care plans because you're so busy. You get pulled up if you don't do care plans and you get pulled up if you don't provide care. If you had more time, designated time to do care plans...... it's important. (DS20 staff)*

*Soms times I feel we rush things. We haven't got the time and we're rushing about. If somebody goes off the floor, and you're left alone trying to get everything done. It might be me pushing myself. I never stop! (DS 25 staff)*

There was a feeling of being constantly under pressure and feeling dissatisfied with care given. Thus there was often a lack of a sense of achievement.

**Feeling able to deal with issues**

Strong leadership and role models was something that staff valued in helping to develop confidence to deal with issues in the workplace.

*Soms times when I am acting up some people don't listen, I go back and ask again. Chris is my role model. (DS 24 staff)*

*When I come here if I have any problems or ideas, or anything that bothers me I can go to Beth. (DS 24 staff)*
Having key responsibilities was valued by some staff. It helped them to have a sense of achievement in their role:

*We are not responsible anymore for some of the things that we used to be involved in eg review, phoning GPs. I would have seen people in their own homes before. It was very worthwhile. We felt proud and special. When we are key workers it would be nice to be involved in the review.*

(DS20 staff)

**Formal training and informal learning**

Formal training for staff was available and staff did find these opportunities helpful:

*We get training as well. Medication training and infection control. I learned a couple of things that I didn't know before. We're able to ask questions. I've got SVQ 3.* (DS 25 staff)

A culture of learning where it was easy to ask questions was valued to support putting learning into practice and enhance confidence:

*Training I feel supported doing my SVQ. They help with my written work, give me pointers. They told me that if I needed help I could ask for it. It's easy to ask. I don't feel intimidated.* (DS 20 staff)

*I feel a bit silly when people are using words that I don't understand. I don't know what they are talking about. I ask about it.. If people can't tell me or don't have time I could look it up. There is a computer here that we can do that.* (DS 26 staff)

*Things I don't know about when the doctor comes in and uses big language. I feel awkward. I try and get and someone else to go in and I would go in as a second person to learn.* (DS 26 staff)

*Managers and colleagues listen to me. Linda helped me calm down before my interview. Knowing that you have people to ask for help* (DS 26 staff)

**Using supervision**

Supervision is a mandatory requirement for all care home staff and appears to be valued by them. It is an opportunity for them to offload their issues and be supported to continue in their valuable role

*We can use supervision to sound off.* (DS 20 staff)

*I get feedback at supervision. Every time I act up or doing things well whether it's good or bad.* (DS 24 staff)

Interestingly when staff are formally invited by letter for supervision, this is pleasing for them and supports them to feel valued:
Supervision can be supportive. I was pleased. It was different. We've had training for supervision. I was invited by letter to go for supervision. Not just a name on a board. The issues I raised were resolved. (DS 24 staff)

The physical environment where supervision takes place can be variable for staff. They recognise that the optimum environment would be a private dedicated space for effective supervision to take place.

Theme 8: Promoting a positive culture

Below are some headings and quotes that sum up for people what a positive culture in the home looks like.

**Feeling heard**

*If there is anything they are always attentive, they listen to you. If I had anything to say I would definitely approach the staff. I feel as though they are friendly. They would listen* (DS14 Relative)

*My thoughts would be respected. They would not brush me off, they would listen* (DS14 Relative)

**Feeling welcome**

*Always have a chat with whoever lets me in. I know them all. I'm in every day and gradually by coming in I get to know them.*

*Cheery faces, get a gut feeling, familiarity with staff members. Welcomed when you know who is on with you.* (DS 20 Staff)

**Feeling valued - Feedback and support**

A strong theme identified was being valued and thanked for the difficult role staff had and the importance of regular feedback to motivate and inspire them

*I feel like I'm doing a good job but it would be nice to be able to ask for feedback.* (DS 26 staff)

*I have a team leader. When I was doing my SVQ I nearly gave up and found it hard. Angela helped me and so did the team leaders.* (DS 26 staff)

*Getting feedback from others, being thanked for your work* (DS 24 staff)

*If I have a problem it's good to get feedback. Mainly positive feedback and get the answers.* (DS 24 staff)
Connecting with each other

We have a chat about everything. They ask what I’ve been up to? I can ask how's my mum and they always know. (DS14 relative)

We make friends at work, general staff attitude of what's going on. (DS20 staff)

Good feedback from residents and their families. When you go home and feel good about what you have done. New training and policies -having knowledge helps with confidence. If families ask a question and you come across as being knowledgeable. (DS20 staff)

Being authentic and real

Because the staff are not putting on a face for us. We've not a set time for her. We just drop in when we’re passing. We don't feel ask were a burden when we come first thing in the morning. (DS 23 relative)

Having a good time

Come in and hope for the nice day. Thinking positively and have a good time with clients. 1:1. (DS 24 staff)

Working together and supporting each other

Some staff expressed strong emotion in relation to working with others, particularly if there was a perception that they were working harder or more effectively than others. Negotiating with fellow colleagues and support from management was helpful in managing the workload.

I get frustrated when I go into a drawer for things and it's not there. Need to go the laundry to get clothes. Need to get aprons and gloves. It would be better if everything was in the room or the bathroom. Staff need to be aware that they need to put it away and some staff are lazy. You get used to it and I just tidy it, but it makes me angry. Some staff don't tidy up as they go. (DS 25 staff)

9 times out of 10 I feel capable. Mainly from the staff I work with. It can be difficult. Sometimes I can say if it's hard if people are not pulling their weight. I done management years ago and I know who to manage people. Sometimes I can challenge, but its hard. I ask people to let me know if I leave the floor and also when they come back I let them know. Some staff waste time. My training helps. (DS 25 staff)
Stress at work. Not getting help when I need it. Too many things happening at once, lack of leadership from team leads. 3/5 are good shifts. (DS 24 staff)

**Feeling positive and proud**

Proud of everyone in here. We have all different problems and issues in life and we all still come in and do a good job. (DS 24 staff)

There can be a lot going on, it’s stressful, try to have a positive attitude and make it infectious. (DS 20 Staff)

**Being treated with respect**

The majority of staff are nice. A couple of staff are not so nice and create problems out of nothing....... People treat me with respect they help me if I ask them. It’s ok most times sometimes they ask do you need help. (DS 25 staff)
Aspirations for the New Care Homes

A total of 3 days was spent, one in each care home, holding individual focus groups with residents, families and with staff to explore their aspirations for the new home. The participant breakdown is shown in the table below:

<table>
<thead>
<tr>
<th>Home</th>
<th>Residents</th>
<th>Relatives</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Home A</td>
<td>5</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Care Home B</td>
<td>3</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Care Home C</td>
<td>-</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

Collage work

To help the discussion, each group was invited to consider what mattered to them about the home. They were invited to look through magazines for inspiration and together create a collage with words and pictures that encapsulated their individual and collective thinking about the new home and the meanings it held for them.

On each occasion themes from the data already gathered from observation and emotional touchpoints were shared with the group at the outset. Everybody was aware of and excited about the new care home and keen to share their perspective. The participants asked lots of questions about the location and the design of the new home. The facilitator was unable to respond to these questions because of lack of knowledge, but this was helpful in releasing participants from constraints and encouraging them to move beyond preconceptions to exercise their creativity and imagination in supplying their own answers.

All groups enjoyed the experience of working in this way. In total 9 collages were created. The topics were then themed and crafted into 3 collages, one for each participant group, with some core themes emerging as important for residents, relatives and staff. The final collages are visually displayed below and supporting commentary provided.
The following themes were identified during the collage work with residents:

**A Welcoming and Comfortable Space**

Residents want the new home to be an ‘ideal home’, one that exudes warmth, is welcoming and has home comforts like a fire and comfortable furniture, consistent with the Talking Points outcome *I have a nice place to live.*

**A Valued Space within the Community: Inviting the Outside In**

The residents were keen to have a familiar ‘High Street’ look to the home with shops that they could go to, and importantly which might invite people from the wider community in. In keeping with this desire to *belong to a community*, a beauty salon which could devote appointments for residents, but also accommodate appointments for their families and neighbours was also mentioned.

**Private Space**
The respect for privacy afforded by having an en-suite bedroom was something some participants were looking forward to, as many residents currently have shared toilet and bathroom facilities.

A Space to Hold Memories

In terms of their rooms, residents wanted space to hold their clothes, memorabilia and other things that were important to them, and plenty of storage space.

A Space to Live and Be

Residents were also interested in having plenty of space within the home itself, with wide corridors and lots of windows to see out of and enjoy the view, highlighting their desires to have space to move around in and to feel connected with the outside world, rather than feeling confined.

The literal importance of ‘space’, both personal and shared, maps to the Talking Points outcomes I have a nice place to live and I live life as I want.

A Space to Care for Others

Other possibilities that residents identified included a kitchen in their unit where they and their families could enjoy a cup of tea together or perhaps even a meal. A guest room was also suggested, so that relatives could stay in the home with their loved one if they were ill, dying or they were visiting from outwith the area. This maps to the Talking Points outcomes I see people and I belong to a community. Interestingly, the importance of attachment extended beyond family and friends, with some residents keen to have a pet other than fish in the home.

Space to Engage in Valued Activities

In terms of having things to do, the residents were happy with the usual ‘tried and tested’ suite of co-ordinated pastimes like quizzes, themed events, bingo etc., but were also interested in the future potential of technology. Sky TV was a particular desire, as none of the homes currently offer football or movies. A Food Club run by the chef in the one of the homes was something the residents were really enjoying and would like to continue in the new home. They also articulated their keenness to help with preparing food and participating in baking and simple cooking activities, enhancing a sense of continuity and maintaining identity. It is thus important that ‘having things to do’ is not narrowly interpreted as being kept occupied or entertained. Activity can be a source of pleasure and enjoyment, whether conducted alone or in the company of others, but it can also sustain valued roles and fulfil a sense of purpose, creating genuine opportunities for older people to continue to make a contribution to the lives of others.

A Listening and Enabling Space

Residents were happy to be included in this consultation as their home is very important to them. Indeed, residents wanted to be heard and were still very much able to articulate what they did and did not want. Sadly, they felt it necessary to highlight that they did not want to be seen as ‘stupid’. Despite being older and recognising that they were dependant in some
ways, they were keen to promote their abilities more generally, as reflected in their wish to continue to participate in everyday activities such as cooking, and they and were still very interested in promoting their health and *staying as well as I can*. It is important therefore that the home takes the form of an enabling and listening space, consistent with the Talking Points Outcomes *I have a say in decisions about my care, I am listened to and I live life as I want*, and reaffirming the importance of the nature of relationships with staff.

**Staff (DS 31 DS 29 DS 32)**

The discussions and collage work with staff addressed both the physical and human infrastructure of the care home, exploring what matters to staff themselves and also for residents, as summarised in the following themes:

**Staff space: A space to relax**
Staff were keen to have a comfortable, well lit environment where they could relax quietly and benefit from their time away from the workspace. They particularly mentioned having a staff kitchen with microwave, fridge and other mod cons. They would love comfy seats and a TV, and perhaps a drinks and food vending machine. They would also appreciate separate changing and showering facilities. Having a space to de-clutter the mind was supportive of the notion of caring for self, and also for others.

**Staff space: A private space**
Staff were also interested in having a private confidential, dedicated and comfortable space for supervision and training.
**Staff space: Proper office space and the potential of IT**
Staff highlighted that currently care plans tend to be written some distance from the residents’ bedrooms. Staff would appreciate appropriate Information Technology being purchased and present in the residents’ rooms so that care plans can be co-created with the resident in real time, consistent with an ethos of shared decision-making. This technology could also be used to access appropriate information with and for residents e.g. accessing Google Earth to see where residents used to live.

**Residents’ space and storage**
In terms of what staff desired for the residents, they would appreciate more clocks around the home, and mirrors in appropriate parts of the home. Rooms specifically for activities and music were mentioned, as was having Sky TV, which would be good for movies and also sport which residents cannot access on terrestrial TV.

Other facilities which they identified as needing to be extended in the new home were the hairdresser and the laundry. They also mentioned that a shop for residents and for staff would be appreciated.

Staff were keen that residents had a nice outlook and also places where it would be safe for them to walk. All agreed that having access to outside space would be great. In terms of the residents’ rooms, they recognised the residents’ need for privacy and felt that they should have the choice of being able to lock their rooms, perhaps with a digital fob.

To make their work safer and more effective, staff wanted space in the residents’ bedrooms to accommodate hoists, commodes and other items of equipment, contributing to their sense of security and achievement. Storage is currently an issue for all homes and they were keen to see clever storage options within the bedrooms.

**Activities to enjoy together**
Many staff enjoyed the range of activities that can be offered within the home when there is time. They would however appreciate an activity co-ordinator as activities only happen when there is time. The importance of outside space was again mentioned, particularly for relatives to enjoy, adding that there was nothing nicer than to sit in the garden with the residents. Attending to local wildlife, like squirrels and birds, was seen as a desired activity for both staff and residents. A common theme with residents and relatives was the notion of a nice salon for clients and staff, which could also encourage community use. Finally, staff would like to get out more with the residents on day trips, enhancing the senses of belonging and purpose for all.

**Creating good teamwork and making work easier**
Providing the opportunity for teamwork was important to staff now and in the future. In particular it was felt that perfect harmony could be created by providing clear roles and job descriptions for domestic and care support staff, rather than the current melding of roles, increasing staff’s sense of purpose. Communication between staff would be improved and
some prevailing issues would be resolved, e.g. care plans would be fit for purpose, increasing a sense of achievement. Practical suggestions like a phone which could be carried around by a member of staff, or an intercom for staff might also enhance communication between staff members on duty. All agreed that working consistently in one area provided continuity of care which they, residents and relatives all valued.

Being heard and having a voice which was listened to were both important, as was their ability to also support this for fellow colleagues, families and residents alike, enhancing the sense of significance for all.

**Being valued and recognised**
A lot of the conversations with staff revealed that many of them would appreciate a uniform of some type, perhaps a nice top and tunic, but something that would identify them and reduce the need for them to wear their own clothes. They would also love some recognition for their hard work and suggested ‘Employee of the month’ or ‘shining star’ award. This would also help them to take time to care for each other, enhancing their senses of belonging and significance, and fostering a more positive culture.

**Questions that staff asked about the new homes**
What transport is available like train and bus links?
What is the location?
How can they get more information about the new homes?

**Relatives (DS 30, DS 33)**
The discussions and collage work with relatives again explored both the physical and human infrastructure of the new care home, primarily addressing what they felt was important for the residents, although touching upon their own needs and aspirations, as summarised below:

**Managing the Transition to the New Home: Continuity of Staff and Knowing the Person**

In relation to the move to the new home, having continuity of staff who could help the residents make the transition well was of paramount importance. Relatives spoke about the need for their loved ones to be known by staff, so that their subtle mood changes and personality nuances would be recognised and accepted by staff who cared for them regularly, rather than relying on agency staff or blending existing staff groups from the ‘old’ homes. They did not want their loved ones to feel emotionally lost in the new home and emphasised the importance of their inclusion in decisions. They spoke about the sense of loss in terms of an ‘empty nest’ that their loved ones felt when they first came into the home and were concerned that this might happen again. This relates to the Talking Points Change outcomes *I have settled in to where I am living* and *my confidence / morale has improved*, as well as the Quality of Life Outcome *I feel safe*. The support of staff who knew the person would be critical in offsetting this, consistent with the Talking Points process outcome *I am treated as an individual*.

**Managing the Transition to the New Home: Meeting Way-Finding Needs**
Expanding on the above, relatives also expressed their concerns that their family members might be physically lost in the new home. Good signage, both pictorial and words would be appreciated around the home, and they would like individual rooms to be easily recognised by the resident, with their names in a proper nameplate on the door to enhance the senses of security and belonging. Such features would also be valued on an ongoing basis, as would a key to lock their door.

**Beyond Transition: Improving the Physical Environment**

The relatives’ aspirations for the new home were broadly similar to those expressed by the residents and centred on *having a nice place to live*. They talked about wanting a homely, happy, comfortable, small unit setting, with lots of windows to allow their relatives to see the views. Many again spoke about the need for adequate storage space in the residents bedrooms for clothes so that they could be stored tidily. Space to store their equipment e.g. wheelchairs and hoists would be vital. Their personal choice of furniture, bedding and towels was also considered important in maintaining identity. Relatives echoed the residents’ appeal to provide a tea making facility in the home that they could use, or a café, but offered the rationale that this would provide a focus for their visit, consistent with the ‘positive visiting experience’ theme previously uncovered, rather than as a means of enhancing the senses of continuity, achievement and significance that residents identified, by enabling them to sustain traditional roles, routines and relationships.

Many families spoke proudly of the heritage of Clydebank and mentioned the memorablia which at present can sometimes be displayed randomly around the homes. They would like any memorablia to be displayed properly to reflect its importance, again consistent with the resident *having a nice play to live*.

**Beyond Transition: A Space for Worship or Contemplation**

Some families mentioned how important faith and spirituality is to their loved ones and suggested that the new home might have a Spiritual Room where services could be held, residents could have communion/mass with their spiritual leaders, or that would offer a quiet space for contemplation for all who visit, live or work in the care home. This holds the potential to contribute to each of the Talking Points Quality of Life outcomes for residents, while enhancing the senses of security, belonging and continuity for all.

**Beyond Transition: Having Things to Do**

Relatives spoke a lot about their distress at their family members having nothing to do and how, in their view, there was virtually no stimulation for them. Some commented that the home is not a hospice and that the residents are alive. However, what they see is residents just sitting there with the TV on, which can either be too loud or too low, and which gets them (relatives) down. Whilst some were keen for their loved ones to be doing something, they also recognised that when staff did organise activities, the residents sometimes were not interested, too tired, or could not be bothered to take part.

Despite this, being entertained was still seen as important. Relatives were not particularly interested in their family members learning new activities per se, but wanted them to be
involved at a level the residents themselves were comfortable with. They said that their loved ones in general just wanted a simple life. ‘Sometimes we think they need this and that and sometimes all they need is a good blether, and a good laugh’

Families came up with a list of things to do which might occupy their loved ones:-

- People to entertain
- Music
- Everyday activities like setting tables, folding napkins, dusting, perhaps preparing vegetables
- Art therapy: Parents used to go to an art class
- Beauty therapy: Many residents still wear make-up. Students could come in and work with the residents
- Garden for residents to work in
- Teapot afternoon chat
- IT facility
- Dominoes, jigsaws, keep fit, and other regular activities

Beyond Transition: Ongoing Relationships with and Support from Staff
Relatives spoke of the need for staff to have the residents as their first priority, citing the importance of mutual and reciprocal relationships, consistent with the Talking Points Process Outcomes I am treated as an individual, I am valued and treated with respect and I am listened to.

They recognised that there are different levels of expertise and knowledge within the staff group and that some staff are more expert than others in terms of how to look after people living with dementia. They all recognised that staff do not have a lot of time to spend with residents, other than to provide essential care. More staff would be appreciated by relatives to provide the level of care they would like to see, contributing to the Process Outcome I can trust staff and rely on them to respond.

Building on this, whilst buzzers were available in their bedrooms to access help, families suggested that sometimes their loved ones might need help when not in their room, or indeed in bed, and perhaps wearing alarms would help.

Relatives Own Needs and Aspirations: Knowing and Working with Staff
Consistent with the My Home Life theme of shared decision-making, relatives spoke of their keenness to be partners with staff and residents. Many of them are expert in their knowledge of their loved ones, and in other fields as well, and they felt that this expertise could be usefully ‘tapped into’ if known about. The importance of being known to staff and for them to know staff and to be able to speak to each other by name was important for them. Relatives wanted to be able to recognise staff and would like them to wear name badges. Some would like staff to wear a uniform, whereas others valued the fact that staff did not wear a uniform as it did not look so institutional.

Relatives Own Needs and Aspirations: Being Kept Up to Date
Relatives also spoke about their interest in notices as a means of getting information, but were critical that sometimes the notice boards for residents and relatives were not always kept up to date. They would also appreciate regular information through a newsletter from the home, enhancing their senses of security and belonging.

Photo Language Work

The staff, residents and relatives were also asked about their aspirations for the new care homes using photo language techniques. Participants were presented with a wide selection of photographic images and invited to choose the one that best encapsulated their aspirations. The chosen images and supporting commentary referred to both the physical and human infrastructure and reflected many of the themes identified through the collage work, as detailed below.

Creating and Sustaining Community: A Happy, Welcoming and Comfortable Environment

The importance of having a nice place to live, visit or work in and belonging to a community of happy, familiar people was conveyed through several photo choices:

Speaks of happiness to me (DS 13 Resident)

Feeling of weightlessness and openness. What would help? I find that difficult to answer. Everything is just nice (DS 21 staff)

Cat on the mat cosy and comfortable and relaxed I would feel great. I like the fact that there are no uniforms. Not a strange person in a uniform that feels like hospital and institutions. Be able to identify cosy colours of red orange (DS 22 relative)

Comfort and coziness. Nice atmosphere, furnishings. Folk milling around. You can feel it, see it. You can tell when people are relaxed (DS 24 staff)
Looks nice, sun makes people happy. If there’s lots of light in the room. The way we can be light. Tone of voice and the way we speak (DS 27 staff)

I love a sunset (DS 28 resident)

It’s nice here, they’re nice people. (DS 21 resident)

When I retire I will move to a wee village where I will know everybody and will notice if someone's grass is growing and I can offer to help. Would be nice if you could have a village feel like this in the care home. Caring for others, helping out, noticing things if the grass is long (staff DS 6)

While residents spoke about the importance of feeling welcome in the present moment, relatives voiced concerns about the future and whether the new home would be as welcoming. Concerns about managing the transition were also expressed by staff, including their own concerns and frustrations.

Made me very welcome here. I’m a strong minded person and make the most of what I’ve got. (DS13 resident)

I want to feel as welcome as I feel welcomed here...they know us by name. I don't know what it will be like in the big home (DS 22 relative)
Hoping they feel welcome in the brand new place for staff and people. Hoping the older person can cope with the change. Hope they will last. They're going to a bright place, it might help. Staff worry about redundancies. Design of the new build will hopefully have lots of folk going about and the rooms looking on to a big area where they can see what is going on. Frustrating for staff because they don't know what is going on. (staff DS4)

Creating Community: A Place to Live and Be

The importance of being able to feel connected to the outside natural world, of community as something living and feel alive was also reflected through image choice.

Need to have good views with something to see. Having windows to see out. And wee balconies that can sit in with a bigger window. (DS 25 staff)

Nice outlook and nice place for a walk where it's safe to walk (DS 31 staff)

Getting out, more outings for residents (DS 31 staff)

There is a bit of life to the place – that’s important to feel alive (Relative DS1)
Looking at it in a nurturing sense. I’m nurturing the home along - a parent role. It’s a nice feeling (DS 21 staff)

Creating Community: Inviting the Outside In

The importance of people coming in to the home and having a place within the local community was also shared through photo selection.

I want it to be a happy place or at least as happy as it can be with lots of different ages of people coming and going. (relative DS8)

I would want ducks in the new care home. Everyone can feed the ducks doesn’t matter who you are. It’s nice to feed things makes you feel good that they are eating up. It’s outside. Kids may want to come up and feed the ducks (Resident DS1)

Caring Relationships and Being Listened To:

Several participants chose imagines to reflect the importance of being caring relationships and being with people who listened to and understood them:
I like talking about memories if somebody listens to me (DS21 resident)

Speaks of happiness (DS 23 relative)

Having a good relationship with the clients. Reciprocal thing of getting to know each other. How can we do that better (DS 27 staff)

Want to be listened and heard. Opportunities when they have something to say. When people are heard, they know something is going to be done (DS 24 staff)

Listening and being heard. For them to be heard and also for us to be heard. Please listen. (DS 30 relative)

We need to be heard and we need to listen to clients and families (DS 31 staff)

**Being Safe, Feeling Safe:**

The importance of a safe community identified through the emotional touchpoints stories was reiterated through staff, relative and resident image choice, evidencing the different notions of safety at play.

Safety in the new home and people can go to their own room and it was their home and do whatever they like (DS22 relative)

Residents should be able to lock their door or have a fob (DS 30 relative)

Bain of my life for offices need digital fob for rooms (DS 31 staff)
Kids don't have worries. That's what my aunt has said she wants (DS 22 relative)

Being in safe hands and a safe place. (DS22 relative)

Don't want them to feel lost either in the emotional context or physically. To be included. Good signage pictorial and words. Anti glare. A place for their name plate. (DS 30 relative)

Creating good team working and making work easier:
The theme identified by staff through collage work was again evident through their choice of images, and also echoed by relatives.

Hikers look like a band of brothers all going together in the same direction. Hope we do that. (staff DS3)
Sometimes it feels like everything is going round and round but it does not fall in place. What helps? Staff working as a team. In my head everything is twisted around, but somebody can help me and the wires are all unwound.

I want everything to work like clockwork. Team work helps. Things in place in the home to manage things a bit easier like where to get information - easy access (DS21 staff)

Rules are very important to provide structure that works for everybody (DS24 staff)

...keeping up the joined up working. All held together (DS22 relative)

**Having enough staff to care for and spend time with residents:**

A final theme to emerge was the pressures on staff, and the desire for them to have more time to spend with residents in the ways that they would like.

I feel I am a fast worker like a draughty wind. I’m always busy and maybe don’t have time for others cos I am so busy. I’d like this time (DS21 staff)
Everybody is hands on with everybody relaxed, more time to watch TV and reminisce with residents (DS 21 staff)

Time to spend with clients. (DS 31 staff)

Need plenty staff. More staff would be beneficial for the client. We could take the resident out and they would not be restricted. We wouldn't have to tell them they would have to wait (DS 25 staff)

Need an activity coordinator (DS 31 staff)

Running all the time to get things done.... Sometimes you feel like a robot. Dual role cleaner and caterer. Used to be able to take clients out. Dependency level increased. Trying to do the simplest things can be tricky. It is a challenge. Up against the clock. Problem of space and manpower. Everybody needs 1:1 care.

More money and more staff would help
We can't do everything.... (Staff DS1)

The final point made by a member of staff touches on a critical issue that has been woven through this report, but not addressed directly, namely the increasing dependency levels of residents. This has significant implications both for the demands made of care staff and also for the continued reliance on an evidence base grounded in experiential accounts from more able residents. This issue receives more considered attention in the Discussion section.
of this report.
Drawing upon the Findings
Capturing the perspectives of residents, staff and relatives using a variety of methods has provided rich, highly contextualised and nuanced accounts of their current experiences of and aspirations for future care home life. It has highlighted many similarities and some differences in aspirations and the level of importance different stakeholders attach to specific issues. Encouragingly, with the exception of the wearing of staff uniforms, there were no conflicting or opposing views, and anticipated tensions between the functions of home life, care and protection that care homes are expected to fulfill were not manifested.

The findings are consistent with *the My Home Life* themes, the *Senses Framework* and *Talking Points Outcomes Framework for Older People Living in Care Homes*, each of which is based on deep and extensive evidence. This enhances their credibility in informing the design of the new care homes in terms of both physical and human infrastructure, as summarised below. However, these findings must also be set against a complex and changing policy landscape that increasingly positions care home life as a last resort.

The work in West Dunbartonshire also suggests possibilities for introducing meaningful ways of evaluating the extent to which the new care homes are making a difference for staff and relatives and achieving valued outcomes for residents. These implications and possibilities are now discussed in turn.

Implications for the New Care Home Design
The residents who took part in the exploratory work spoke mainly about their aspirations for the new home itself and their lives within in, also touching upon what they felt would be important for their families and other visitors. The implications for ‘care’ were generally not discussed. The residents’ aspirations mirror all of the *Talking Points Quality of Life Outcomes*, with *I feel safe* expressed in terms of warmth and comfort of the home, rather than freedom from physical harm. They also reaffirm the importance of Process Outcomes, particularly *I have a say in decisions about my care and I am listened to*.

The importance the residents attached to ‘space’ and the need for distinct spaces permeated the discussions. This finding echoes the wider literature, which highlights that space plays a crucial part in maintaining continuity of living for older people, notably in relation to space as ‘freedom to be’, ‘freedom to care’ for friends and relatives, and as a ‘container for memory’. The loss of space on moving into a care home may alter or deny many aspects of life that may be meaningful to individuals and may inhibit rather than promote human flourishing.
The staff who took part spoke about their aspirations for the home as a physical building and their work within, based upon their own needs and those of residents. Staff aspirations touched upon each of the 6 Senses, reaffirming their value.

Staff’s aspirations for residents echoed those expressed by residents themselves, although very lightly coloured by safety issues and perhaps overlooking residents’ concerns with using their retained abilities, maintaining valued roles and making a contribution to the life of the home. However, the residents who participated in the various discussions had many retained abilities and these aspirations must be contextualised within the diversity of people living in care homes.

Like residents, staff emphasised the importance of distinct spaces within the home, expressing their need for private meeting spaces, spaces to relax and an organised office space. They shared the residents’ interest in having access to a pleasant outside space, better amenities and, to some degree, having a greater place within the local community. They also shared the residents’ aspiration to be listened to and valued, evidencing a shared humanity.

The design of care homes in the past has often betrayed a lack of awareness or even dismissal of matters such as space and having your own things as trivial, privileging function over liveability, with access and safety dominating the architectural component. Personal possessions are powerful and significant in all our lives, especially as we grow older, and smaller personal living spaces and inadequate staff spaces may compromise expression of identity and prejudice preferred ways of living and working. It is therefore essential that communal spaces within care homes genuinely belong to everyone, rather than in essence belonging to no one, and that distinct spaces are available to fulfil the various meanings of ‘home’ and ‘care home’ expressed by residents and by staff.

Whereas residents spoke mainly about the physical infrastructure of the home itself and their status within it, staff also viewed the move to the new home as an opportunity to revisit and clarify roles and responsibilities, to improve communication between staff, and to introduce work patterns that would enhance continuity, thus bringing the ‘care’ dimension of the ‘care home’ more sharply into focus. Within these discussions, the importance of adequate staffing levels and staff feeling informed, listened to, valued and supported was paramount. This included being kept informed about the planning of the new homes.

Many of the themes to emerge from the work with relatives mirrored those identified with residents and staff. However, with the exception of storage space, the central importance of space was not recognised. In addition, one concern that was at the forefront of relatives’ thinking was the transition to the new home and the potential impact on their family members. Relatives were concerned about both the built environment and the care within it, sharing staff concerns that current staffing levels are barely adequate to meet essential care needs and also stressing the importance of residents continuing to be supported by staff who knew them well. Residents had their own needs, including the need for visits to
the home to be positive experiences, and they deeply appreciated having strong and sustained relationships with staff and making decisions together.

Whilst having things to do was identified as important by all groups, the different stakeholders expressed very different ideas about the form and purpose such activity should assume. Some residents were keen to sustain former roles, whereas others were coming to terms with inabilities to persist with favoured interests. Staff wished they had more time to spend with residents and that there was greater scope to support structured and informal activities. Relatives felt the lack of activity most keenly, suggesting it was a source of distress, but also acknowledging that the uptake of planned activities could be low, and that perhaps companionship and the enjoyment of simple life pleasures was a greater priority for residents who were more physically and cognitively frail.

*I have things to do* is positioned by Talking Points as a key quality of life outcome for residents. However, consistent with the relationship-centred approach advocated by *My Home Life*, Talking Points also emphasises that equal attention should be afforded to process outcomes such as *I feel listened to*, which includes being given the opportunity to talk about feelings and emotions, and to change outcomes such as *my confidence or morale is improved*, particularly in coming to terms with losses. It also important that the outcome *I feel safe* is not narrowly understood, that the emotional and spiritual dimensions of safety are recognised, and that a sense of continuity is interpreted as making connections between past, present and future rather than preserving the status quo. Moving forward, there is work still to be done to support staff and relatives to care for older people as they move closer to the end of their lives and to find new ways of being with them until death. In turn, it is essential that organisations value and take good care of the individual members of staff who fulfil these vital roles.

**Implications of the Policy Context**

Looking to the future, in writing this report we are very mindful of the 20:20 vision for Scotland and its impact for the care home sector. The flipside of the aspiration for people to remain at home for as long as possible is that older people are moving into care homes much later, often in crisis situations, when the complexity of their needs can no longer be met elsewhere. Transitions are increasingly unplanned and the cognitive frailty of a growing number of new residents leaves fewer opportunities for building relationships and really getting to know the person. An inevitable consequence of the changing demographic is that death is more commonplace, which can be distressing for fellow residents and for staff.

Through the consultation and our wider engagement with care home managers across Scotland, we have found that managers increasingly believe that many of the initiatives and policies that they are currently expected to implement are based on an understanding of care home life that no longer holds true, and objectives that may not be possible, or indeed desirable, no matter how supportive the care environment.
While there is widespread commitment to developing care homes to meet future needs, opportunities must also be afforded to raise their very real concerns about what this future might hold. Continuing to deliver quality of life for all will require greater honesty about the nature of the challenge, and the energies and good will of everyone involved in the lives of care home residents to be harnessed through positive relationships.

**Implications for Measurement**

Towards an Enriched Care Environment: Achieving the Senses for All

The principles of relationship-centred care have profound implications for the measurement of care home success, insisting that meeting the needs and aspirations of everyone living, dying visiting and working in the care home are understood and supported. The importance of staff feeling listened to, supported, recognised and valued is critical.

In addition, it is essential that *quality of care* and *quality of life* are defined in ways that reflect the very diverse realities of care home residents and the very real constraints and demands that care home staff experience on a daily basis.

As Nolan (1999, p66) argues: ‘even if consensus to quality of care as to a definition can be reached, what value do concepts such as *autonomy* and *individuality* have for individuals who might be both physically and cognitively frail?’

Nolan warns (p67): ‘to present benchmarks for quality which are either unrealistic, unachievable or simply inappropriate does nothing to enhance quality of care, and indeed might even hinder it. They are particularly important for staff who, if set unrealistic or unattainable goals, are likely to become increasingly disenchanted.’

**Outcomes for Residents**

The Scottish Government is committed to adopting an ‘outcomes approach’ in all services and settings, ensuring a central concern with the difference made to people’s lives. Indeed, the commitment to improving personal outcomes has recently been heightened through a series of key strategies and endorsement in forthcoming legislation, notably the Joint Working Public Bodies Bill and the Self Directed Support Act. The Talking Points Personal Outcomes Approach has provided a clear focus for activity around outcomes and personalisation through participation in Scotland and the work in West Dunbartonshire has reaffirmed the salience of the *Outcomes Framework for Older People Living in Care Homes* and its alignment with *My Home Life*.

The *Taking Points Personal Outcomes Approach* is grounded in a relational understanding that is concerned with ensuring that people are supported in ways that are not only effective, but crucially are also responsive to their needs, values and aspirations. It is consistent with a broader understanding of shared decision-making, which ensures that the perspectives of all relevant parties are considered and negotiated, set within a context of what’s possible. This approach also allows the thorny issue of risk to be approached in an informed and, where appropriate, a more enabling manner that considers the potential for physical, social and emotional harm.
It is however its capacity to provide evidence of outcomes for individuals that has caught the eye of those concerned with measuring impact and managing performance. It should be stressed that a preoccupation with ‘proving’ service impact, rather than ‘improving’ people’s lives (and then demonstrating the difference made as a by-product) has many consequences including:

- Privileging ‘service’ outcomes deemed important for individuals over outcomes important to individuals (‘personal’ outcomes);
- Lack of attention to way that care is provided and the intrinsic value of relationships;
- A failure to recognise the contribution of the individual, consistent with an enabling approach;
- Missed opportunities for (or to recognise) genuine partnership working with families, other supports and services;
- A focus on ‘lower order’ outcomes that can be easier to evidence (or ‘count’);
- Distorting effects on practice;

A personal outcomes approach is grounded in engagement, involvement and participation of all stakeholders. This however presents a number of issues and challenges.

Implications for Involvement and Participation
The most significant challenges to resident involvement and participation are supporting their widely differing capabilities and dependencies, notably engaging with the growing number of residents with communication difficulties and more severe cognitive impairments.

It should be stressed that thankfully the negative view of the capabilities of people living with dementia is increasingly being successfully challenged. Growing awareness of the strategies employed by people with dementia in order to communicate has also resulted in a greater understanding of the techniques that care staff and family members can use to support them. It is important to keep an open mind, to avoid labelling people or making assumptions based on test scores that privilege notions of an individual rational actor over relation understandings, and to work creatively with retained abilities. However, it is also important to be realistic and sufficiently flexible to support different levels of impairment. There is a very real requirement to refine current conceptualisation of ‘conversation’ and ‘participation’ to reflect and support the variety found in people living in care homes, their situations and their relationships with care staff and services.

For people with more severe impairments, requirements can move towards providing a safe environment that promotes quality of life for the individual and maintains their sense of person in the present moment. This often places the onus to determine ‘what matters’ on care staff, weaving together relative accounts, where available, with knowledge of the person’s life history and ‘messages’ conveyed in the present, including more embodied communications and expressions.

Work to support consultation with people with dementia in care home settings has stressed that efforts must be embedded within an overarching commitment to good communication
grounded in supportive relationships, starting with a firm focus on communication in everyday life. Creativity, variety, flexibility, knowledge of the individual, attending to environmental factors, and being prepared both to plan and to work spontaneously are critical. Care home staff build up an extensive knowledge of what’s important to each person over time, are able to notice things over the course of the day and night, and with the right encouragement and support are well placed to develop such understandings.

*My Home Life* actively encourages creativity and innovation, together with the use and adaptation of a diverse range of data gathering approaches, conversational, written, visual and observational, such as those used in conducting the work in West Dunbartonshire. It also encourages the ongoing development of an evidence base for the sector. The requirement to assess and continue to improve quality of life within care homes could be an important opportunity for staff to use their existing skills, knowledge and approaches, to experiment and to document their efforts. They could then begin to expand current understandings of what can work for different people, and how best to weave together different sources of information to ensure a plan that is relationship-centred, outcomes-focused and co-created in line with each individual’s capabilities.

The ability to do however will in part be shaped the physical infrastructure of the care home. This report has identified the importance of distinct spaces and architectural design features to ensure an enriched care environment in both a human and physical sense.
References


Appendix 1: Talking Points Outcomes Descriptors

Quality of Life:
Supporting people to achieve the outcomes under this heading may require different levels of support at different times. Good support for individuals as they first move into a care home setting is crucial to ensure these outcomes are achieved over time. Engagement of staff in the care home, the person themselves, other health and social care professionals, family, friends and the broader community will often be necessary to support the individual to achieve these outcomes.

I feel safe and secure: The person feels safe and secure in the care home and in their community. The person is as far as possible physically safe from harm. The person also feels emotionally safe, is able to face the future without fear, and can rely on staff and others to support them when they feel less safe. The person also feels safe in their relationships with others.

I see people: The person feels that they have enough contact with significant other people and that they have opportunities for social participation, if they choose. This can include contact with family, friends, other residents and staff. Individuals have some choice over who they spend their time with in communal areas, who visits and when. Seeing people can be associated with experiences of not being lonely, companionship, friendship, mutual affection and ultimately love.

I have things to do: The person has opportunities to undertake activities which interest them (if they wish). This can include everyday activities, individual hobbies and interests, or group activities. Participation in activities can contribute to feelings of self-worth, being part of a valued group, enjoyment, satisfaction or the achievement of other-regarding goals, thereby making a contribution.

I live life as I want: The person is able to plan and have control over their daily life, such as what they wear, when and what they eat and how they spend their time. The person has the opportunity to reach key decisions about their life and future, recognising the constraints of living in a group setting.

I stay as well as I can be: The person feels that they are as physically and mentally well as they can be, given any illness or condition they have. This includes being supported to stay clean and comfortable, having access to appropriate and nutritious food and drink, support and treatment when the person becomes ill, and the management of any long term conditions, including pain relief and medication.

I have a nice place to live: The person feels that they live in a pleasant and homely environment. This includes personal space, the communal spaces inside the home, any outside space and the environment in which the home is situated.

I belong to a community: The person is able to participate in the life of the community of their choice regardless of illness and disability, and to contribute to life in the home and to the lives of others within the home or a community that they previously associated with.

Process
Outcomes under these headings are the impacts of the way care and support is provided and the ways in which staff engage with and relate to people. This includes care and support provided in the home and by other health and social care professionals visiting the home.
I can trust staff and rely on them to respond: The person feels that they can rely on staff to do what they say they will and to ensure that care and support that they need is in place. The person feels that services respond to their changing needs and that they can rely on services to respond if particular difficulties arise.

I have a say in decisions about my care and support: The person’s views are taken into consideration in deciding on the support they receive and how the routines in the home impact on their life. This includes the use of sensory and communication aids as appropriate. The person is supported in anticipatory care planning to ensure their preferences are known.

I am treated as an individual: The person feels that they are recognised as an individual in their own right, with individual needs, aspirations and preferences. Their experiences and achievements are recognised.

I am valued and treated with respect: The person feels that they are valued as someone who has something to contribute, are respected and treated with dignity, warmth and consideration.

I am supported to live well and plan for a good end of life: The person has the opportunity to plan for the end of their life, including where they would like to die and the arrangements for after they have died.

I am listened to: The person feels that their views about their own situation are listened to by staff and their communication is supported. This includes the use of sensory or communication aids as appropriate.

My family and friends are involved if I want: The person feels they are able to involve their family and friends in their life, including making decisions about and providing care and support. There is recognition of the importance of the continued relationships and the role of family and / or friends as the person moves into the care home.

My privacy is respected: The person is able to be alone when they choose and to receive care and support and pursue interests and relationships in private.

**Change**

Change outcomes result from tackling barriers to achieving quality of life and from managing risks. For some people it may be possible to identify a point at which the change has been achieved or partly achieved, and the focus moves to maintaining quality of life.

I have settled in to where I am living: The person is working to establish their life in the care home and to adjust to the changes associated with a move to a care home. This may include taking time to come to terms with feelings of grief or loss associated with leaving a previous home.

My confidence / morale is improved: The person is working towards dealing positively with changed life and health circumstances, and /or personal and societal attitudes towards ageing, ill health, disability and dying. This outcome domain may be particularly important when the individual first moves to a care home, following loss of a loved one or fellow resident, and at the end of life.

My health has improved or my symptoms reduced: Experiencing fewer symptoms, feeling less depressed or anxious, improved sleep and improved relationships. Symptoms continue to be managed to enable the person to approach the end of life in comfort and to have a good death. Where the person has dementia, he / she is supported to manage the impact of the cognitive impairment on their wellbeing.