## Outcome Report

Presently, the Care Homes Project works with eight care homes: four residential homes and four nursing homes. However, when we consider that 30 beds are equal to 1 unit, we are in fact working with 14.2 care homes.

Though we are confident that the Care Homes Project has indeed contributed to the prevention of hospital admissions, this is very difficult to quantify; there is no formal system currently in place, either with the care homes or the CHMT which documents an avoided hospital admission. We have, therefore, included a series of case studies in this report which documents some of the rich, person centred support we provide to care homes. The case studies below serve as a sample of the work we presently do. Such work has, in turn, empowered care home staff and lessened some pressures for the CMHT. As such, the Care Homes Project is cost effective in terms of both time and money. The case study, Tim, for instance, was almost certainly about to be readmitted to hospital having already spent two months on a ward prior to admission to the care home in question. Tim's previous length of hospital stay is indicative of the financial cost to NHS services and we feel that we have saved the service a comparable amount with our work with the care home.

Names, ages - and in some cases, genders - of the all clients and staff we worked with, have been changed to ensure full anonymity.

## Primary Outcomes

| | **Time 1 10/2012** | **Time 2 01/2013** | **Time 3 03/2013** |
|---|---|---|---|
| **Number of residents: TOTAL** | **205** | **324** | **427** |
| Number of residents in Residential Homes | 94 | 94 | 197 |
| Number of residents in Nursing Homes | 111 | 230 | 230 |
| **Number of residents with dementia and Behaviour that challenges (number of residents who have a care pathway tool): TOTAL** | **27** | **39** | **42** |
| Number of residents with behaviour that challenges in Residential Homes | 12 | 12 | 15 |
| Number of residents with behaviour that challenges in Nursing Homes | 15 | 27 | 27 |
| **Number of residents with an open referral to the CMHT: TOTAL** | **45** | **99** | **99** |
| Number of residents with an open referral in Residential Homes | 24 | 61 | 61 |
| Number of residents with an open referral in Nursing Homes | 21 | 38 | 38 |
| **Number of residents referred to the CMHT service over past 6 months:** | **17** | **16** | **15** |
| **Number of residents currently on anti-psychotic medication:** | **9** | **16** | **17** |
| **Number of transfers to Nursing home:** | **0** | **0** | **0** |
| **Number of transfers avoided:** | **27** | **12** | **3** |
| **Number of hospital admissions in last 6 months:** | **0** | **1** | **0** |

**Case studies**

*All names have been changed to protect client and carer identity.*

**Client:** Tim is a 75 year old gentleman. During his working life he was a chief executive of company. He comes from a science background. Tim and his wife enjoyed travelling and walking events. He was a great lover of DIY and refitted a number of their homes. Tim has a diagnosis of fronto-temporal dementia. Tim has been living in a care home for 18 months, having come from an Oxleas older people's hospital ward.

The CHP became involved with Tim after the CMHT received a call from the care home stating that Tim was hitting out at staff, had been turning furniture over, and had pulled a door off its hinges. Tim was known to the CMHT. The training had just started with the care home.

**Interventions:** Several joint visits were carried out alongside the CPN to the care home. CPN input reviewed and monitored medication. The focus for the CHP was to explore Tim's level of level of engagement and opportunities to engage in activity, the Pathway tool was completed.

**Life History:** Tim had severe difficulties expressing himself in spoke language (expressive dysphasia). It was felt by the team that this could be causing Tim tremendous distress, frustration and could be a factor for hitting out at staff. Linking Tim's life history and his working life he would have had great control and authority. Tim's expertise in DIY was felt to be a very important factor. We felt this needed to be acknowledged.

**Communication:**

The CHP team provided some education and discussion around communication e.g. remaining cognitive and emotional abilities. Despite expressive language challenges it was very likely Tim could understand aspects of verbal language and would be able to pick up on non-verbal communication, body language, facial expression, tone of voice and proximity. The CHP team felt it was important for Tim to feel that care staff, were very aware he was trying to tell them something and that they wanted to know what it was but were also aware that he was having difficulties finding the right words. "We can see you really want to tell us and it must be so frustrating."

**Activity engagement:**

Tim spent a lot of his time exploring his environment in a very tactile way, examining and running his hand along bannisters in hallways, exploring and repositioning furniture in his bedroom and communal areas. Tim was engaging in his environment and activities in a very sensory manner and likely to be very much in his DIY role. The care team developed a rummage box for Tim and provided him with some plastic tools to support his role in DIY. There was also a sensory approach suggested for showering Tim to help cue him into showering.

**Outcomes:**

- Joint working with the care team and Tim's wife, staff are working very much to preserve Tim's sense of self, maintaining his identity and respect and facilitating meaningful activity.
- Tim's wife and care team have relayed that there have been times when Tim has become more vocal and verbalised a short sentence.
- Care home staff have said 'Tim's happy we're happy. He's nice to have around.'
- We are continuing work with Tim in supporting and increasing his involvement in his personal care

**Client:** Mary is an 89 year old woman. She has lived in a care home for 15 months. Mary lost her sight about 20 years ago. Changes with her sight changed plans for her retirement. Mary appears very philosophical when she talks about life changes. Mary describes herself as a private person. Mary has always expressed her keen wish to stand and take some steps when she can. She enjoys spending some time of her own to listen to her radio. Mary has a diagnosis of Lewy body dementia. Mary was reviewed by the team as she had been experiencing an acute episode of hallucinations. During this time she was being hoisted and not able to stand with staff.

**Physical Health:**

Joint sessions with physiotherapist and care staff involved exploring physical health factors. A home exercise programme was recommended. The recommendations suggested that staff continue to use the exercise programme with Mary.

**Life History:**

Mary consented to a personalised plan for leisure activity. 1-1 discussion and London working life reminiscence focused sessions. Mary has a great sense of humour and fun. With a supportive style of discussion Mary has a wealth of knowledge and appeared to working life food markets in London, especially billingsgate market, sporting life. Discussions with activity coordinator lead to recommendations being made regarding activity ideas.

**Environment:**

Chair height raised but did not lead to consistent ability to stand from sitting. During joint sessions with Physiotherapist it was observed that standing was possible from a height variable bed.

We worked with care home staff to promote of the importance of maintaining physical activity and functional ability, even acknowledging variability within someone's day and within that day.

We recommended equipment to promote physical independence.

**Outcomes:**

- Information has been fed back to carers, and we have encouraged a consistent use of 1.1 time with Mary, and not to only engage with Mary when she experiences behaviour that challenges. This has been challenging as staff have not always been consistent with this.
- Equipment recommendation for a rise-recline armchair has been made to maintain and maximise opportunities to participate in sit-stand and walking
- We will review activity engagement with clinical lead and activities coordinator in the care home.

**Client:** Doris is a 92 year old lady with a diagnosis of Alzheimer's type dementia. She has a history of depression and had, over the past few weeks, not left her bed. Staff found that she was particularly challenging during personal care. They described her as being physically and verbally 'aggressive'. A functional analysis was performed to try and identify the key triggers for the behaviour that challenges.

**Interventions:** A functional analysis is a systematic psychological assessment that looks at environmental and psychological cues that could be contributing to behaviour that challenges. In the case of Doris, we wanted to try and detect such triggers and work consultatively with care home staff so that we could formulate a care package that would support them in caring for Doris.

Doris was fed in her bed and was assisted by carer Mark. Doris was able to pick up her sip cup to drink her tea and put toast to her mouth to eat independently. No discernible environmental issues were noted, the room was warm and well lit, however, her bedroom door was open and a hoover could be heard in the distance. Doris was able to use non-verbal communication to communicate her feelings. She appeared dissatisfied with having assistance to eat breakfast. She was able to pull napkins from the carers hand to wipe her own mouth and did this whilst looking at Mark. She would use her arms and hands to push Mark's hands away when she didn't want something offered to her e.g. toast. Though Doris spent the majority of her time making verbal and physical suggestions that she was dissatisfied with Mark assisting her with breakfast, she did eat and drink most of her breakfast and said 'thank you' to Mark once she had finished.

**Findings:**

We were able to communicate to care home staff that it could be that Doris is frustrated with her declining independence. In addition, it may be in Doris' nature to be head strong, and her need to be independent is expressed through pushing, and verbally expressing her dissatisfaction. We felt that it should be noted that Doris is now in bed all of the time and her contact with other people can be sparse. She may be using her time with carers to reinforce her independence. This, therefore, could be an expression of Doris as a person, and carers may wish to perceive this as a positive thing.

We were able to communicate to the care home staff that, by allowing Doris to express herself in this way, they were affording her an opportunity to gain a sense of empowerment that she may not otherwise feel. We were able to reinforce staff by helping them see that they were doing a good job with Doris and that by supporting her in being a powerful woman they were actually empowering her. Staff said that they had not considered Doris' behaviour from this perspective and were able to take our comments on board. We tried to shift staff attitudes in what constituted 'aggressive' behaviour and, through training and follow up work, we have been able to effectively communicate that actions such as moving carer's hands away is actually a form of communication, as opposed to aggression.

**Outcomes:**

- We then focused on formulating a care plan so that staff members supported each other in delivering care to Doris.
- Arrangements were made whereby different staff attended to Doris during the day so that one or two members of staff did not feel overwhelmed by the level of care needed.
- We discussed that it may be useful to recognise that, though it can be hard when a person with dementia declines care, it shouldn't be taken personally and that it can be helpful to share such experiences with the team.
- Staff felt that they were able to continue to support Doris within their care home.