# Working towards the ideal: The changing environment in KCHT homes

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# WORKING TOWARDS THE IDEAL: THE CHANGING ENVIRONMENT IN KCHT HOMES

**A report for Kent Community Housing Trust**

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## EXECUTIVE SUMMARY

1. The study reported here follows up a previous review of resident, relatives' and staff views of five KCHT homes which was undertaken in the spring of 1993. Focusing on the social environment the earlier study examined both perceptions of the `ideal home' and how the homes were operating in practice (Lawson, 1993). This enabled the identification of those aspects of life in the homes where practice diverged most from resident, carer and staff ideals. Since that time a number of changes have occurred. In order to consider how these changes had affected life for residents KCHT commissioned a further study to explore the current situation in the same five homes. There was particular interest in the residents perspective and in the impact of the approaches being taken to resident activities.

2. Home managers, staff and a sample of residents were interviewed or completed questionnaires in order to:

   - describe the changes that have been implemented since 1993;
   - compare the social climate in the homes now with that two years ago;
   - establish resident and staff perspectives of the activity programmes introduced during the period;
   - consider residents' social networks by identifying who residents feel they can draw on from staff, other residents and relatives; and
   - explore resident perceptions of the process of admission to the homes.

3. The changes identified over the intervening period included resident and staff turnover rates, working towards IS9002 accreditation and refurbishment across all the homes.

4. The study focused on the use of staff allowances in order to provide `diversional therapy' or activities in the homes. In two of the homes this allowance had been used to employ a specific individual with responsibility for organising and encouraging activities. In the three other homes existing care staff provided activities on specific shifts.

5. The residents who were interviewed, selected to participate in the study because they were the most mentally able, were found to participate in a wide range of activities. Staff and residents tended to identify different types of activity, suggesting an overall under-reporting of the

level of occupation.

6. The number of activities that residents were involved in was related more to the targeting of specific types of resident than to the way that diversional therapy was organised in the home. The rate of participation was higher in homes where specific diversional therapists were employed.

7. The sheltered care environment scale (SCES), completed by both staff and residents, was used to measure the social climate of the homes. This was compared with the measures obtained two years ago. For the most part homes appeared to have moved towards the ideal (see figures 1 and 2 and table 1). From the staff perspective there was a statistically significant increase in levels of Cohesion, Organisation and Physical Comfort and a significant decrease in levels of Conflict. Residents experienced a significant increase in Independence. The only exception to this very positive picture was Resident Influence that appeared to have declined over the period.

8. The measures of Cohesion and Independence had increased more and were at an overall higher level at the time of this study in the homes which employed diversional therapists.

9. The social networks of residents were examined by asking residents who they would turn to in certain situations. Residents turned primarily to supervisory staff and to friends and relatives outside the home when they had a personal worry. Friends and relatives outside the home dominated when there was a social celebration and supervisory staff would usually be approached when there was a concern about the care being provided (see table 5).

10. Residents felt that the admission process was managed well. Many did experience a falling off of staff attention over time, which is, perhaps, inevitable.

11. The overall picture was very positive. There clearly must be reservations about drawing causal connections with so few homes but it appeared as though the employment of diversional therapists had a beneficial effect on the life of the homes in terms of Cohesion and Independence. The refurbishment seemed to have had a noticeable affect on the Physical Comfort scores.

12. Areas where KCHT might wish to focus future efforts include:

    - ♦ encouraging staff to see occupation and activities as important elements of the caring process, linking resident needs in a broader sense to the activities provided;

- staff sharing experiences across the homes to consider what works (particularly for people with dementia) and how best to facilitate the least able to benefit from activities;

- a review of complaints procedures; and

- new approaches to involving the more alert residents in the life of the homes.

## 1. Background

A study of resident, staff and carer views of five KCHT homes was undertaken in the spring of 1993. Focusing on the social environment the study examined both perceptions of the `ideal home' and how the homes were operating in practice (Lawson, 1993). This enabled the identification of those aspects of life in the homes where practice diverged most from resident, carer and staff ideals. Since that time a number of changes have occurred including a comprehensive programme of refurbishment and the accreditation of all of the homes with the IS9002 rating. Partly in response to the study findings homes have been encouraged to make use of specific allowances for staff to encourage and organise activities for and with the residents.

In order to consider how these changes had affected life for residents KCHT commissioned a further study to explore the current situation in the same five homes. There was particular interest in the residents perspective and in the impact of the approaches being taken to resident activities. When considering the resident's perspective on the homes it was decided to focus on their relationships with others as this is likely to be of primary importance to their quality of life in a communal setting.

The objectives of the evaluation were to:

- describe the changes that have been implemented since the last study;
- compare the social climate of the homes now with that two years ago;
- establish resident perspectives on the activity programmes introduced;
- consider residents' social networks by identifying who residents feel they can draw on from staff, other residents and relatives; and
- explore resident perceptions of the process of admission to the homes.

The report begins by outlining the study methodology and describing the changes that have occurred over the two year period between the two studies. This provides the context for the changes in the social climate in the homes which are discussed in section 4. Section 5 identifies the activities undertaken by the sample residents and section 6 the characteristics of their social networks. Section 7 briefly describes the residents experience of admission and the implications of the findings are explored and discussed in section 8.

## 2. Methodology

Home managers of the five homes that participated in the 1993 study were interviewed to establish changes which had occurred since then and to provide an overall perspective on the management of activities in the home. In addition one or two members of staff actively involved in organising and providing activities were interviewed. They were asked about the way that activities were organised generally and about the activities of the residents who were being interviewed. KCHT also provided information about staffing of the homes.

To measure the social climate of the homes and facilitate a comparison with the previous study, a sample of twenty members of staff in each of the five homes were asked to complete questionnaires which incorporated the Sheltered Care Environment Scale (Moos and Lemke 1984), used by Lawson (1993). This consists of 63 questions which are used to generate seven dimensions covering relationships, personal growth and system maintenance and change (see Box 1). A sample of residents were asked the same questions to establish the resident perspective on the homes.

Forty residents were interviewed (the objective was to obtain 10 from each of the homes which had sufficient numbers of residents who were mentally capable of taking part). In addition to the Sheltered Care Environment Scale (SCES) a series of questions explored the residents' experience of the activity programmes, who they would approach in three hypothetical situations to explore their social network and an open ended question about their experience of the admission process. In practice only 34 of the residents interviewed completed all three sections of the interview. Information on activities and/or social network were collected from a further three residents. Mental state difficulties resulted in several interviews with other residents failing. These were gradually brought to an end by the interviewer.

When analysing the SCES data cases were omitted where less than seven responses were available for any one dimension. This was particularly the case where confusion was created by terminology (for example, reference to `rules' often confused both staff and residents). The low numbers of residents completing the SCES for each individual home meant that no significance testing of differences in residents' views between the different homes would be valid.

## 3. The homes: changes over the past two years

Inevitably all the homes will have changed in one way or another during the period between the two studies. Even in the absence of any alterations in policy, homes will evolve over time: for example, residents and staff move on, quality assurance mechanisms and long term policies will affect the care provided. These factors in turn will affect the social climate of the homes and residents' experience of living in the homes. It is not possible to identify all

the influences and the likely direction of effect on the life of the homes. It is helpful, however, to clarify those areas where changes are known to have occurred and to specify their extent as far as possible. Clearly changes in the resident and staff populations and the physical environment will be expected to impact directly on residents. When considering the care provided the study focused on the development of activities programmes (or diversional therapy) in the homes.

### *3.1 Residents*

All home managers mentioned increased levels of dependency. Some indication of the extent of this can be gained from resident turnover on the assumption that more dependent people are being admitted and that long-standing residents tend to be relatively stable. Home managers were asked how many of the current residents had been in the home for two years or more. Overall about half the current residents had been in the homes for more than two years. The turnover was highest in two homes where 35% of residents had been in the home for two years or more and lowest in the home where 70% of residents were so long-standing. One of the homes where there had been the highest level of turnover also noted that long term residents were noticeably deteriorating. Another home manager had noticed an increased number of people needing wheelchairs as well as an increase in the number with dementia.

The sample of residents interviewed were not representative of the homes as they were selected on the basis of their ability to participate. Fifteen of the 37 sample residents had been in the home for two years or more. Their average age was 84 years.

### *3.2 Staff*

Staffing levels in four of the homes had increased during the previous two years. KCHT's policy objective is to get the level of staffing in all non-enhanced homes up to 15 hours per resident.

During the past year about 90 residential care staff members had left the five homes. This represents about a third of the number of staff employed at any one time. There was considerable variety between the homes with one home having just 15% of staff leave during the past year. The home where turnover was highest had almost half the staff complement leave in that time. In many cases this reflects rapid turnover among a number of very short term staff. A good proportion of staff have been in post for many years. Among the sample of staff who returned the questionnaire 90% had been in the home for two years or more and over 40% had been a member of staff for six years or more.

A new manager had been employed at Pilgrim's View shortly after the last

review. He had changed staff shifts to reinforce the resident groups and ensure continuity of staff for residents through residents being got up and put to bed by the same people.

The home which had the highest level of staff turnover during the two year period also had a lot of sickness at the time of the study. Insufficient casual labour supply (due primarily to DSS rules) meant that although the resources were there recruitment was not always possible which led to a certain amount of stress among existing staff.

*3.3 Physical environment*

The programme of refurbishment had affected all the homes during the past two years. This consisted largely of redecorating although more extensive work had taken place in some homes. For example, adaptations had enabled group living to be introduced to Lennox Wood.

*3.4 Activities*

Allowance has been made in the staffing of the homes for the employment of diversional therapists whose role is to organise and encourage resident activities. The homes have used this allowance in different ways.

In one home (Hevercourt) one 9-5 shift is an `activity shift'. Theoretically this takes place every day but in practice such shifts occur at least three or four times each week. During this shift the member of staff is responsible for ensuring that residents are encouraged to get involved in activities. This can be as low-key as a one-to-one chat or as planned as a regularly organised craft group. What takes place is up to individual members of staff who are encouraged to draw on their own interests and strengths. A day book in which the member of staff records what was done and with whom is used by team leaders and members of staff on the activity shifts to ensure that all residents get involved in something. In practice, however, if residents appear to be content, are not keen in getting involved in activities and staff feel they are able to express their wishes, then these residents do not get approached other than in the course of normal care and socialisation.

In another home (Pilgrim's View) a few key members of staff were involved in specific activities that were undertaken as part of a day shift once or twice each week. Other care staff help to get residents to a given location. The home manager was actively involved in instigating activities from within and outside the home. Within the home the emphasis was on encouraging existing staff to draw on their interests. Team managers ensured that all the residents were as involved as they wanted to be. Spreading the sense of involvement to more members of staff was regarded as important. It was thought that this would allow a sense of `back-up' when for various reasons

the named members of staff could not get involved. In practice additional work due to resident sickness meant that activities ceased to occur when the nominated staff were hard pressed or absent. This home had the advantage that a range of activities were provided by an occupational therapist, part of a special support scheme provided by the Health Authority, who visited the home twice each week.

This practice of nominating specific individuals to undertake activities on a particular shift was also adopted by Churchlands. Again there was some back-up in the form of regular visits by an art therapist. The home manager was not involved with the development and instigation of activities and there did not appear to be a mechanism for ensuring that all residents activity needs were covered. When the level of care hours was raised the previous autumn the decision had been made (in the light of staff sickness) to employ a male care assistant rather than use the resources for diversional therapy. Staff changes meant that the scheme did not seem to be operating other than nominally at the time of the study.

The two other homes had adopted a very different approach. In each case an individual member of staff was recruited and employed to act as the diversional therapist. The home manager supervises and monitors but the diversional therapist co-ordinates and implements a wide range of activities. The diversional therapists had no relevant formal qualifications but considerable enthusiasm and related interests. The diversional therapist at Hartley House was a new employee when KCHT took over the homes in 1992 and has been developing the activity programme since then. The diversional therapist employed in Lennox Wood arrived in June 1994 and followed a very similar approach to that developed in Hartley House. They each started by talking to all the residents to get an idea of what might be of particular interest before setting in place a structured plan of activities. In each home a timetable was on the noticeboard describing when each type of activity was available. The structured plan included opportunities to sit and chat with those residents who preferred this type of involvement to more specific activities or who were unable to get involved in anything else. Hartley House had the added advantage that it had the use of a mini-bus allowing frequent trips out and about. One disadvantage mentioned with respect to this type of approach was that other staff can see activities as the diversional therapists province and not part of their own role in caring for residents.

### 4. Social Climate

The dimensions of the Sheltered Care Environment Scale (SCES), used to describe the social climate of the homes, are described in Box 1.

**BOX 1: Sheltered Care Environment Scale (SCES) Dimensions**

| | | |
|---|---|---|
| | | Relationship Dimensions |
| 1. | Cohesion | - measures how helpful and supportive staff members are toward residents and how involved and supportive residents are with each other. (e.g. Do residents get a lot of individual attention?) |
| 2. | Conflict | - measures the extent to which residents express anger and are critical of each other and of the facility. (e.g. Do residents ever start arguments?) |
| | | Personal Growth Dimensions |
| 3. | Independence | - assesses how self-sufficient residents are encouraged to be in their personal affairs and how much responsibility and self-direction they are encouraged to exercise. (e.g. Do residents sometimes take charge of activities?) |
| 4. | Self-Disclosure concerns. | - measures the extent to which the resident are encouraged to openly express their feelings and (e.g. Are personal problems openly talked about?) |
| | | System Maintenance and Change Dimensions |
| 5. | Organization | - assesses how important order and organization are in the facility, the extent to which residents know what to expect in their day-to-day routine, and the clarity of rules and procedures. (e.g. Are activities for residents carefully planned?) |
| 6. | Resident influence Influence | - measures the extent to which the residents can rules and policies of the facility and the degree to which staff direct residents through regulations. (e.g. Are suggestions made by the residents acted upon?) |
| 7. | Physical pleasant comfort | - taps the extent to which comfort, privacy, sensory satisfaction are provided by the physical environment. (e.g. Can residents have privacy whenever they |

| want?) |
|---|

Between them the seven dimensions provide a picture of the home's social `character' or climate including how supportive the home is felt to be, how organised, how stimulating. The main focus of interest here is how the homes appear to have changed on these dimensions over the two year period, particularly how the current situation compares with the ideal situation from the perspective of staff and residents. These two perspectives are considered in turn.

*4.1 Staff perceptions*

Figure 1 shows the overall picture comparing the situation in the five homes in 1993 with the ideal expressed by staff at that time and the situation in 1995. Table 1 gives staff and resident real and ideal mean scores on each dimension. Overall, progress appears to have been made towards the ideal. Statistically significant changes were recorded in five of the dimensions:

- increased levels of Cohesion ($p<.06$), Organisation ($p<.01$) and Physical Comfort ($p<.01$); and
- decreased levels of Conflict ($p<.05$) and Resident Influence ($p<.01$).

The changes in the other dimensions were insufficiently marked to be sure any real change had occurred. With the exception of the difference in Resident Influence all the changes were in the direction of the ideal.

Generally the results for individual homes tended to mirror the pattern overall. There were exceptions, however. For example, in one home levels of Cohesion had significantly declined over the period.

*4.2 Resident perceptions*

The lower numbers and the fact that only two of the homes had information about residents perceptions of the prevailing social climate in 1993 make comparisons over time difficult. Table 1 shows resident average scores with staff perceptions and those of residents' ideals established in the previous study. Figure 2 depicts residents' perceptions of the homes in practice in 1993 and 1995 and the ideal scores established in 1993. In order to display as complete information as possible all the homes for which information is available are included. The figures are not directly comparable as in the 1993 study residents from two of the homes provided 'ideal' ratings and residents from two other homes provided the 'real' ratings. In 1995 all four of the homes provided `real' ratings.

Where comparisons were possible a similar pattern of changes was reflected in the residents' and staff scores, that is movements were generally towards the ideal. It was interesting to note that the only statistically significant difference in the two homes where the resident perspective was available was for increased Independence ($p<.05$). Independence was one of the few dimensions where the change in staff perceptions was not statistically significant.

Overall average scores for most dimensions in 1995 appear to be close to the ideal expressed in 1993. Although we know that staff and residents' views of the ideal differ in some respects, from both perspectives the results appear to indicate an overall improvement. Comments made during the individual interviewing of residents allowed a deeper insight into each of the SCES dimensions. These are discussed in turn.

*Cohesion*

The Cohesion sub-scale measures how helpful staff are towards residents and how involved residents are with each other. The degree of attention given by staff was generally seen as being related to need: the more needy get the more attention. Some residents felt that they had received more attention in the past, but they felt this had gradually reduced over time. Many also felt that the homes were short-staffed which meant they were always busy: "They don't waste time". Many commented on the fact that they could get attention through using a bleeper when needed. Staff were generally thought not to talk down to residents; one added that "They don't dare to!"

Social grouping was used in several homes, which made for more family size dining and sitting arrangements, but could have some restrictive effects, particularly where there are a large proportion of 'confused' residents. A few of the residents interviewed attempt to communicate with the more confused people:

> "We need to try to talk to people, to explain things more: they are not so bad as one thinks they are".

But unless there are frequent joint activities where they can regularly meet similar others in the home, there can be some loss of continuity and the mentally able may find themselves a little isolated:

> "People die and no remarks are made. Here to-day, gone tomorrow"
> "Only about ten people to talk to."

It can be particularly difficult for those who have severe sensory impairment. "Minds can be OK" but can lack communication with others when deaf or deaf and blind, as much as those who are confused. Deafness was the reason why one resident felt she could not take part in many activities and another felt

reluctant to communicate with others because her accent was difficult for others to understand. Difference in age group can also be an isolating factor: with an age span of approximately 35 years between the oldest and youngest resident taking part in this study.

*Conflict*

The Conflict sub-scale measures the extent to which residents are able to express anger and be critical of the facility. Comments from residents show different schools of thought: whereas some respond to the questions by emphasizing friendliness:

"We look after one another"
"All moan at times: nothing to moan about really but makes a conversation"
"Some very argumentative but also cheerful"
"May get told off but seem to want to get told off"
"Wish it were noisier - it's too quiet"

others view things differently:

"Some criticise each other"
"A lot won't let other watch TV because they talk loudly"
"Some in joking way, but some upsetting".
"Residents complain over food a lot".

They mostly feel that staff would intervene to stop any situation developing into real trouble such as physical conflict.

Generally residents are more upset by disruptive people or events, which can occur when there is a resident who makes a lot of noise, or those who have very bad table manners, although they tend to be philosophical when talking of this: "Some are very noisy: gets you down". Interestingly staff were seen by some as being stricter on rules over table manners, perhaps because of the effect upon other residents. Theft is another issue which can create conflict and which some residents complained about, having to take extra care to lock their rooms.

*Independence*

This assesses how self-sufficient residents are in their personal affairs and how much responsibility and self-direction they exercise. Independence was seen by residents to have increased considerably towards the ideal since the previous study.

Many residents were unsure about how much residents were learning to do new things; they felt that many residents "wouldn't be able to do things on their own" although there were some who recognised that they themselves

were becoming more able:

> "Yes, learning to do more things on our own now more than before."
> "Learning how to walk on leg again after breaking it."

The diversional therapists were valued; classes were mentioned, and one resident commented that through developing lots of activities the diversional therapist "has done a lot for residents".

Others create and maintain a role for themselves in the home by taking on some domestic chores, such as helping before and after meal times (washing up, laying table and so on). Another grows tomatoes in the gardens, and one goes shopping for others. This appears particularly important in enhancing personal identity, but it does require a degree of physical ability which few have.

*Self Disclosure*
This measures the extent to which residents openly express their feelings and concerns. On the whole residents felt more able to talk to staff about problems than to other residents. Some felt that personal problems are best kept to themselves or close friends if any.

> "Don't discuss personal problems in a large group: may in a small group"
> "Some might talk of their fears to a suitable carer."

But where residents have established closer friendships, they feel they can discuss problems and "unburden themselves" which they see as good for them: "More like a family". Anything that encourages residents to develop friendships amongst themselves would, therefore, appear to be desirable, and anything that brings them together in a situation where they can interact, such as group activities particularly where the tasks involve co-operation, must be conducive to this. Many residents have seemed to enjoy preparing for fetes and open-days where they have a common purpose.

*Organisation*
This assesses the importance of organisation in the facility and how explicit the rules and procedures are.

There did not appear to be any problems with Organisation in the homes. Although residents did not always know when staff would be around they could use the bleeper to contact a staff member. This, of course, is from the perspective of alert residents, able to use such facilities. Generally residents were seen as being clean and usually tidy, as staff deal with mishaps immediately. Change and confusion was not seen as occurring disruptively in the homes; confusion was mostly seen as attached to residents, not the home

itself. It was mentioned that frequent changes are problematic for those with sensory impairment as well as those who are confused.

*Resident Influence*
This measures the extent to which residents are able to influence the rules and policies of the facility and the degree to which staff direct the residents through regulations.

Views about Resident Influence varied among residents, with some feeling the opportunities for contributing ideas and suggestions are provided by staff, and others feeling that although they recognise they can make suggestions, they are not in the position of decision making. Nevertheless good suggestions have been seen to be acted upon and some active residents felt they could change things if they had a majority in favour.

> "Invited to say what could be altered - but can't please everyone".
> "Talk together to decide how to do something."

Rules were elusive: many felt there were not any, but some recognised that there must be some underlying rules which are not explicit but depend on how important the issue is, how much the result of not intervening impinges upon other residents. Staff intercept, for example, not allowing things to go too far,.

> "No rigid fear of rules but most know what should be done".

*Physical Comfort*
This taps preferences for comfort, privacy, pleasant decor and sensory satisfaction in the physical environment.

Decoration in all the homes unanimously received praise, but some residents found problems with furniture, particularly chairs being uncomfortable. Lighting was mostly seen as very good, although a few mentioned the disturbance caused by too much light at night where rooms have transom windows onto corridors.

Physical comfort for many people related most importantly to their own room: "My room is my home". This was very important for them, and offered them as much privacy as they needed, allowing them to please themselves about the hours they kept, which television programmes they watched, and how they spent their time, thereby leading as normal a life as possible. Most had some of their own furniture in their rooms and chose their own decor which personalised it more. Fear of others wandering into their rooms when they are not there leads many people to keep the door locked, and some would not agree to go on an exchange which was being organised with homes in France, because it would mean someone using their room who may leave it unlocked.

Some chose to be in their own room most of the time because they did not want to mix much with others, or found few people they would wish to mix with. This needs to be borne in mind when considering increasing the intake of those with dementia, particularly in group living. Some people still shared rooms and one commented that he shared with people who came in short-term, which was sometimes difficult for him. Another had the offer of a single room, but turned it down because she felt a degree of responsibility for the person with whom she shared.

It was with heating and ventilation that most problems arose, particularly in rooms such as the dining room which can get too hot or too draughty if windows and door are left open. This is a difficult problem to tackle in that what is "hot and stuffy" to some is just right for others. Some commented that when staff are working they are not aware it can be too cold for some residents. Having one's own room and the facility to control the degree of heat or fresh air is valuable. The problem remains in communal facilities such as the dining room.

## 5. Activities

It is important to bear in mind when considering the evidence about resident's participation in activities that the residents interviewed were all relatively mentally alert and as such represent a particular sub-population of the homes. Most residents in the homes do not fall into this category. Information about resident's perceptions of the activities was only available for four of the homes.

### *5.1 Participation and attitude to activities*

Of the 37 residents interviewed 33 did at least one activity. Residents identified about two different activities each on average. The types of activity and the number of residents who mentioned them are identified in table 5.1. Each resident was involved in some activity an average of two to three times each week although this included a very wide range: from those who do something every day (excluding reading and watching TV) to those who were not involved in anything. In some cases this was because the resident had severe sensory impairment and found it very difficult to undertake any activity.

It was interesting to note that staff, when asked about the residents who were interviewed, identified a similar number of activities on average, but the activities named were rather different. They focused less on outings and social events and included more individual activities such as walking, manicure and reading. They tended to include going out to the pub and to the local shops, whereas residents often saw this as part of their normal life rather than as an activity. This would indicate that there was under-

reporting of residents' level of occupation overall.

Overall the number of activities which sample residents were engaged in did not vary much between homes. The exception was a home in which the average number of activities was noticeably lower. This home had a policy of targeting staff efforts on the least able (primarily those with dementia). It was not surprising that as a result the most able residents represented by those who were interviewed, participated in fewer activities than those in other homes.

Residents started activities either because they were asked to or because they did this activity before they came to live in the home. Only three residents said that they had been asked what they would like to do and had suggested the activity. All the activities identified in table 2 (with the exception of outings) were mentioned as activities that residents had done before admission.

For the most part residents clearly enjoyed the activities. The benefits they identified are shown in table 3. The most frequently mentioned was stimulation. This did not appear to be related to any particular sub-set of activities.

Fourteen residents identified something they disliked about at least one activity but the problems expressed were very varied. Dislikes included not being able to see properly, feeling ill on the coach, not enjoying the music, people smoking and that the activity did not happen often enough. In most cases only one person mentioned each reason. The exceptions were two people who felt ill on a coach and two who disliked the music.

Staff were also asked how they felt that residents benefited from the activities. The benefits identified included:

- maintaining a level of activity in the home so that there was a sense of a lot going on;
- enabling individuals to do more;
- enabling individuals to get a sense of achievement;
- encouraging a sense of independence;
- enjoyment;
- companionship;
- continuity with the past/ reminiscence;
- reality orientation;
- physical mobility;
- mental stimulation;
- spiritual development;
- soothing and calming;

- gaining experience of other parts of the home;
- opening up otherwise withdrawn individuals.

There was no consistent integration with the care plans other than ensuring that notes were written up about individuals. Often this was seen as a chore rather than of any active benefit to the residents. In some of the homes residents were consulted and activities designed to fit in with their preferences. But only in a few specific instances was there any link made with resident needs and activities undertaken. This tended to occur if there were instructions from a health professional that a resident should take exercise. Generally staff did not identify resident occupation as part of the caring process.

*5.2 Organisation of activities*

The way that activities were organised in the homes has been described above (section 3.4). The difference in approaches raises the question whether one approach rather than another is more effective in fostering activities and independence in the homes.

The homes were classified into two groups depending on whether a diversional therapist was employed specifically for the task of coordinating, encouraging and organising activities or existing care and supervisory staff took on this responsibility. In terms of the number of activities which residents were engaged in there was very little difference. But average frequency of involvement in activities was higher in the homes which employed diversional therapists (over three times each week compared with under twice per week in the other homes).

It has already been identified that the interviews only revealed the perspective of the more able sub-population of residents in four of the homes. The SCES scales give a broader picture of the homes. Indeed, it was noticeable that when residents answered questions for the SCES that referred to residents they tended to exclude themselves and reply with respect to residents with dementia. Table 4 shows the average scores for the SCES scales when the homes are classified by activity type[1]

For both staff and residents in the homes which employ diversional therapists specifically for the purpose Cohesion and Independence scores were noticeably higher. For staff the difference was statistically significant ($p<.01$).

[1] The scores for residents and staff are not directly comparable for those homes which do not employ a diversional therapist as information about resident views was not available for Pilgrims View.

The same was not true for Resident Influence which might also have been expected to be affected by activity levels in the home. This is the scale that causes most difficulty for completion as it refers to rules and regulations which both staff and residents have problems identifying.

## 6. Social Networks

The third section of resident interviews concerned their social network within and outside the home, looking at how the degree of social support may differ between residents. The method used here is a traditional social psychological approach developed by Jenkins (1948). The technique has been used in various forms since, mostly through mapping people's social contacts in relevant task situations, which is the method adopted in this current study. Three categories were established to see who residents would invite or talk to in each of three hypothetical circumstances:

- *social event*: who would you invite if you were having a birthday celebration?
- *personal worry*: who would you talk to if you were worried about a friend or relative?
- *care concern*: who would you go to if you were worried about the way a new member of staff was treating people?

*Social event*:
This question proved to be the most difficult because of the practice in the homes of marking the occasion of a birthday at teatime, which meant that many residents included all the staff on duty and residents in their invitation, although a few did distinguish specific staff and other residents when prompted. It was with friends and relations that a more differentiated response occurred with 23 residents suggesting between one and eighteen friends or relatives they would invite or with whom they would spend their birthday (see Table 5). Table 5 does not include those giving the more generalised open invitation, but only includes residents who specified particular staff and/or residents. The number of people invited ranged from one to all of the supervisory staff, among other care staff between and one and half a dozen and among other residents between one and nine (this last reflecting the number of residents in a lounge).

*Personal Worry:*
This question revealed that when residents had a personal worry they were more likely to approach supervisory staff (in ten cases just the home manager) or relatives and friends, with just eight of the 37 choosing to speak to their keyworker. Other staff and other residents were not substantially consulted on a personal worry, although six people said they would approach long established staff they knew well. Only three residents would approach

another resident. The number of residents they would consult ranged between one and three.

*Care Concern:*
Responses to this question showed a distinct emphasis on supervisory staff, with practically half of the residents (eighteen) choosing this path, and six choosing their keyworker. Seven would approach a member of care staff who was not their key worker or another member of staff. Again these would be the longer established members of staff that they felt comfortable with. When asked how many staff this included those residents who could specify mentioned up to six. Only four residents felt they would approach a relative or friend (in each case only one) and none would talk to other residents on this issue. Nobody mentioned any complaints procedures or having received any information on how to complain.

The results showed considerable variation in who would be approached, (relative, friend, resident and which type of staff) according to the different circumstances. Notably the number of residents who would approach supervisory staff grew according to the severity of the event: from minimal for the social event, a lower number for personal worry with the highest for care concern. Contact with other residents decreased as the circumstance became more severe. Relatives and friends played a minor part when the issue was a care concern, although they still played a large role in personal worries. It appears instinctively right that higher management should be approached in these circumstances, although worrying that very few would talk to other residents, none in fact for the care concern. A particular issue is the fact that nine residents would not approach anyone at all about the care concern preferring to keep quiet about it.

## 7. Admissions

Open-ended questions asked of residents at the end of each interview explored how they had felt at the time of admission. For the most part residents described their reasons for needing to come into a residential home. Most had come in directly after an episode of hospitalisation, and/or where their deteriorating physical condition meant they could no longer live in their own homes without substantial care, which relatives were not able to provide. Although the few who came from other less satisfactory homes experienced an immediate improvement, generally people felt very strange at first and took some time to get used to not living in their own home.

Many said they would obviously prefer to still be living at home, but realistically they realised they could not and had come to terms with this. Where people had some familiarity with the home before, either through people they knew living in the home, or through respite or day care, they appeared to settle in more quickly. One resident had been considerably

heartened by being told by the manager:

> "This is not a prison, and you are not a prisoner",

which changed the way she viewed her new living situation.

Most of the residents commented that they appeared to receive more staff attention when they first arrived, and seemed to think declining attention over time reflected increasing staff shortage and overwork.

Although many residents commented on the decrease in attention, most took the opportunity of this section to say how satisfied they are with the home they are living in and that they would not want to change it or move. The following comments are typical:

> "Staff are very good"
> "No complaints - very happy here"
> "Couldn't wish for anything better - get everything here."

## 8. Discussion

As `before and after' measures the SCES scores provide a useful picture of the development of the social climate of the homes over the two year period. Lawson's (1993) study at the beginning of the period identified the ideal and clearly there has been some movement in this direction. Resident and staff views of the ideal differ with residents tending to show lower expectations in such dimensions as Independence and Resident Influence. As a result their scores of what is actually happening in the homes are typically closer to the ideal than staff views. This would suggest a high level of resident satisfaction overall, reinforced by the comments reported above.

There is still room for improvement, however, especially from the staff perspective and it is worth bearing in mind that the expectations of this generation of elderly people tend to be low. Moreover, there was some concern among the residents when they were interviewed that the results of the study might result in some undesirable changes. It is useful, therefore, to investigate the pattern of change to see if this suggests the areas where the homes are clearly getting it right and where improvements may be made[2].

The limited information collected about resident and staff changes over the period did not indicate that changes in social climate were associated with resident or staff turnover. In terms of quality standards, however, it was

[2] It is important to note that caution needs to be taken when attributing possible reasons for change over time with so few homes and no clear idea how much these homes vary over time in dimensions of social climate.

interesting to note that those homes which were following the application for IS9002 through at a slower rate all had significantly higher Organisation scores in 1995 than they had in 1993. The `fast track' homes either declined or stayed at a very similar level to that in 1993.

*8.1 Resident Influence*

One area in which observed changes across all the homes (from the staff perspective) was not in the direction of the ideal was Resident Influence. There is some concern about this measure because it includes a number of references to rules that respondents often find difficult to answer. When discussing the issue directly residents opinions varied. Some thought they could get things changed but often residents felt they did not have the power to make decisions and that any suggestions were unlikely to be acted on.

Other evidence that suggests that the degree of resident influence is an important issue includes the wide divergence in views of the `ideal' levels of Conflict and Self Disclosure established by Lawson in 1993. Residents set these very low (21 and 33 respectively) compared with staff (71 and 87 respectively). Staff perceive the Conflict items as presenting a lively and assertive scenario, whereas many residents see conflict as disruptive and aggressive. Staff and residents form two distinct groups within the homes, with residents dependent, and thus much less powerful than staff. Where one group is less powerful than another it would be expected that the less powerful group would perceive conflict as more threatening and self-disclosure as risky.

Most outcome studies have found a high level of association between locus of control and quality of life (Challis, 1981). Maximising residents' sense of control and influence would seem, therefore, to be an appropriate objective of care. The imbalance in power between staff and residents is to some extent inevitable. This is especially the case with residents who have dementia who form a large sub-group within the resident population. Issues of control with this group are likely to be restricted to their own day-to-day lives. But the role of alert residents in the homes may benefit from further development (see section 8.5 below).

*8.2 Physical Comfort*

The impact of the refurbishment programme was clearly noted by staff with significant increases in the scores for Physical Comfort across most of the homes. From the residents perspective the improvement was not so dramatic. To some extent this was due to their higher rating of the level of Physical Comfort in 1992. They still rated the level of Physical comfort higher than staff in 1995.

Although close to their `ideal' physical environment there were a few reservations. For example, residents did find the temperature and ventilation uncomfortable at times and lighting at night caused problems for some residents. An issue not included in the SCES scale but raised by some residents was that chairs were not comfortable.

Problems with chairs were also raised in a recent study of design of residential care units for people with dementia (Kelly and Carr, 1995). The problems noticed during this study may give an insight into the issue for residents in KCHT homes. The Kelly and Carr study included direct observation of residents behaviour in six homes. The authors noted that:

> The seats to many of the chairs were observed to be too high for some residents, whose legs would not reach the floor. These residents were observed to shift and move a lot in their chairs, apparently trying to get comfortable, and would then get up and move to another chair where the same thing was observed to happen. (p28)

Although footstools were available in all the homes they were rarely used. They also found that chairs were often covered in a wipe clean material which became hot and sticky in the summer months. The problem was overcome in one home by giving residents cushions to sit on, which in turn exacerbated the problem of seats that were too high. Although residents often brought furniture in for their bedrooms in only one case did a resident have her own chair in a communal area.

*8.3 Organisation of diversional therapy*

The employment of a specific individual to provide diversional therapy seemed to have a beneficial effect on the levels of Cohesion and Independence in the homes. This was both in terms of improvements over time and in absolute levels during the period of this study. It was noticeable that in the home where activities had the lowest priority the staff perceptions of Independence and Cohesion had actually fallen during the two year period. In the other homes where mainstream care staff generated and organised activities, the levels of Cohesion and Independence stayed at a similar level or slightly improved.

Caution needs to be exercised in drawing conclusions from these relationships. To some extent underlying changes in the homes will affect both the operation of activities programmes and the levels of Cohesion and Independence in the home. However, it was clear from the interviews with staff that where care staff took on the role of diversional therapist or did special shifts the activity programmes tended to reduce or cease at times of pressure on staff. In some cases the staff leading the activities felt that other staff thought they were shirking or `having it easy'. In practice the more

committed staff found the work demanding, especially those involved in craft related activities who often took preparation work home.

The wide range of benefits identified by staff demonstrates the potential of activities to contribute substantially to residents' quality of life. But even in the homes that employed diversional therapists there was a tendency to view the activities as `icing on the cake' rather than an integral part of care. The results of this study suggest that how the home provides for residents to occupy their time is of importance in developing homes in the direction of the ideal.

Even in the homes where the most progress has been made there is still some way to go before Independence and Cohesion approach ideal levels. If diversional therapy is actively contributing to these positive changes further progress may be made by building on the expertise and experience already evident in the homes. At the time of the study one meeting had been held by the diversional therapists from a number of KCHT homes. This and related initiatives to allow staff to share ideas, approaches and resources could be a fruitful way forward. It was noticeable during the course of the study that problems encountered in one home were sometimes being successfully addressed in others.

When considering the occupational needs of residents it is useful to distinguish between those with dementia and the more mentally alert. In several of the homes people with dementia were found to respond well to music. Staff often found such residents more responsive if they took them away from the area where they normally sat and had a focus for discussion such as a short video or a walk in the garden. Nolen (1987) suggested a four step programme for meeting the activity needs of withdrawn or confused elderly people: establishing communication using statements rather than questions and non-verbal means, rituals regarding time and expectations of residents, ties to the external environments and consistency across staff. Physical exercise can also be beneficial. Snyder (1978) identified that it is possible to reduce wandering by meeting needs for self directed exercise and security[3].

Although there is obviously a certain amount of overlap the occupational needs of alert people are rather different. Benefits of activities which have been identified in the literature for mentally alert older people are: companionship, compensation, temporary disengagement, comfortable solitude, expressive solitude and expressive service (Tinsley et al, 1985). Social groupwork has been found to develop a sense of belonging and

[3] There is little guidance on the best way to meet the occupational needs of people with severe dementia although a special interest group in this area is being set up by Tessa Perrin at the Bradford Dementia Centre at the University of Bradford.

togetherness (Carey and Hansen, 1985-6). Wells and Singer (1988) suggest that benefits of activities are enhanced when they have some purpose and go towards achieving ends the residents themselves desire.
It was noticeable that staff did not mention developing a sense of community and belonging within the home, nor contributing to the life of the home, as benefits of activities. These may be particularly important to alert elderly people who can feel rather isolated and apart from others in a home in which a high proportion of the residents have dementia.

*8.4 Social Networks*

While the question about celebrating birthdays was not successful in identifying the social links of residents it was interesting that even after prompting nearly a third of the residents (twelve) did not name one specific individual that they would invite. Residents turn primarily to supervisory staff and friends or relatives outside the home overall. This, together with the resident comments during the Cohesion section of the SCES (see above) suggests rather weak personal links with the people with whom they spend the majority of their time: other residents and care staff. Part of the reason for the lack of links with care staff is probably due to the fact that the type of residents interviewed in the study saw staff as hard pressed to provide the care required. Although the actual staffing levels had increased over the two years residents felt that staff were becoming increasingly overstretched. In real terms this may be an effect of residents individual experience of staff helping them during the difficult transition time immediately after admission to residential care.

KCHT may wish to consider whether the current complaints procedure for residents would pick up all causes for concern given the proportion of alert residents who would not approach anybody if there were a care problem and the lack of awareness of residents about the appropriate mechanisms.

*8.5 Facilitating resident participation in the homes*

Linkages may be made in the process of addressing issues raised above. Encouraging and facilitating resident influence in the homes could focus on specific practice issues and in the process could foster the role and networks of alert residents.

One approach might be to use the diversional therapy programme as a platform to draw together groups of interested residents to consider practical issues of concern. The results here would suggest the issues of interest would include temperature control, the problems with chairs, or the process of admission to the home. If the last was of interest they could identify what they would have appreciated from other residents and how to counteract the sense of feeling strange when they first arrive in the home. More involvement

earlier with other residents may go some way to alleviate the sense that residents had of staff attention tailing off after an initially high input. In a study by Wells and Singer (1988) residents initiated a formal welcoming committee as part of a programme to improve quality of life of residents and enhance the home's social climate.

Residents already contribute to the running of the home through fetes and similar events. Such activities bring staff, residents and relatives together in a way that can develop the sense of community within a home. There is never a shortage of reasons to raise money. For example, although ambitious, raising money for a mini-bus would have considerable benefits for residents. The residents of the home which had managed to do this were able to get out of the home on a spontaneous basis and involved in the local community to a far greater degree than in other homes.

At a more corporate level KCHT may wish to consider the involvement of residents in reviewing policies such as complaints procedures or quality assurance mechanisms. It is not an easy process involving users in the development of services but provides a valuable dimension which can not be obtained otherwise. It may also serve to develop residents networks within and between homes.

## 9. Conclusion

For the most part the homes are making noticeable progress towards the ideals expressed in the Lawson's 1993 study. Some initiatives, such as employing diversional therapists appear to be having a measurable impact on the life of the homes. Overall residents are clearly very happy with what the homes are providing. Suggestions for possible ways forward include reinforcing existing initiatives in the homes, such as bringing together diversional therapists on a regular basis.

The issue of user involvement in the development, planning and delivery of services is of increasing importance in the provision of community care services (Philpot, 1995). The findings here suggest that, if successful, new approaches to involving the more alert residents in the life of the homes could result in considerable benefits to the residents and the homes.

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**TABLE 1**

| Staff and residents SCES mean perceptions in 1993 and 1995 together with ideal ratings identified in 1993 | | | | | | |
|---|---|---|---|---|---|---|
| **Dimension** | **Staff real 1993** | **Residents real 1993** | **Staff real 1995** | **Residents real 1995** | **Staff Ideal** | **Residents Ideal** |
| **Cohesion** | 52 | 55 | 61 | 60 | 91 | 67 |
| **Conflict** | 76 | 47 | 67 | 42 | 71 | 21 |
| **Independence** | 33 | 30 | 38 | 44 | 73 | 52 |
| **Self Disclosure** | 64 | 30 | 66 | 35 | 87 | 33 |
| **Organisation** | 47 | 66 | 59 | 73 | 71 | 78 |
| **Resident Influence** | 82 | 54 | 74 | 49 | 86 | 53 |
| **Physical Comfort** | 58 | 76 | 75 | 80 | 83 | 93 |

**Table 2 Activities identified by residents and staff**

| Activities | Number of residents who mentioned activity |
|---|---|
| Outings | 15 |
| Bingo | 14 |
| Social events | 12 |
| Crafts | 9 |
| Discussions/reminiscence | 5 |
| Reading | 5 |
| Games | 4 |
| Contributary activities (eg helping out at fetes) | 4 |
| Clubs or day centres | 3 |
| Other | 6 |

**Table 3 Attitudes to activities**

| What resident felt they got out of activity | No. of residents (n=33) |
|---|---|
| Stimulation | 23 |
| Companionship | 16 |
| Getting out | 14 |
| Fun | 13 |
| Sense of creativity or achievement | 9 |
| Helps to pass the time | 3 |
| Helping/ contributing | 3 |
| Enjoyment of winning | 2 |
| Exercise | 2 |
| Relaxation | 1 |
| Nothing | 1 |

**Table 4 Use of diversional therapist and social climate**

| Sheltered Care Environment Scale | Staff | | Residents* | |
|---|---|---|---|---|
| | DT employed | Care staff do DT | DT employed | Care Staff do DT |
| Cohesion | 73 | 51 | 69 | 54 |
| Conflict | 62 | 72 | 49 | 41 |
| Independence | 50 | 29 | 50 | 36 |
| Self disclosure | 65 | 66 | 32 | 39 |
| Organization | 76 | 46 | 69 | 78 |
| Resident influence | 76 | 72 | 47 | 51 |
| Physical comfort | 85 | 68 | 71 | 82 |

* Information about the residents' views about social climate was only available for four of the homes. As a result resident and staff views are not directly comparable