Social work's contribution to improving the quality of life and well being of older people living in residential care

Relating the work to Marmot policy's objectives:

Enabling young people and adults to maximize their capabilities and have control over their lives ☒
Strengthening the role and impact of ill-health prevention ☒

1. **In what ways was the care home achieving less than optimal outcomes for the people in their care?**

Care home. Approx 20 beds. Residents all over 65, some with physical health difficulties, some mental health problems both functional and organic.

The referral came through a safeguarding case conference meeting where other social workers had expressed concerns about the treatment of individual residents.

Social/meaningful activity Although there was an activities plan, it was difficult for residents to read it (small font, too high on the wall) and activities were the first thing to be cancelled if there was a staffing shortage. The arrangement of the furniture in lounge meant that it was difficult for visitors to sit with their relative and the TV was always on very loudly. This meant that although residents were able to communicate, they could not hear each other speak. When asked if they were bored, they did not even think that other options were available to them.

Lack of choice Residents did not have a choice about whether to have a bath or shower, whether to have bubble bath or radox, or the time of day, morning or evening, when they could have a wash. The language used in recording responses in the file suggested that the resident was at fault, that they 'refused' and were being awkward. Acceptance of assistance can often depend on the way that a resident is asked.

Residents in the lounge said they were thirsty. Blackcurrant squash was provided for everyone whether they liked it or not. Some expressed a preference for a cup of tea but were told it was not time and that the trolley would be along shortly. When the trolley came one resident said that she did not like the small cups on the trolley and would like a big mug. She was told that the small cups were all that were available however when the social worker had visited previously she had seen large mugs in the lounge.

Dignity Residents appeared unkempt (which is unsurprising having seen the number of refusals in the bathing records) most residents needed a hair wash. The home has a salon but no hairdresser has been arranged. Some residents had dirty clothes, food down their fronts and mouths/chins that needed to be wiped. A number of residents were noted to have long nails. This was apparently as a result of the home waiting for the District nurse to visit as the residents were diabetic. There was no evidence of the home having chased up the D.N visit and no excuse for the dirty state of the nails.

The lounge had a strong odour of urine. The owner said that the carpet had been cleaned however the level of odour was still unacceptable. Residents were being expected to sit with this all day.

All residents were having their toilet habits recorded. This would be necessary in the case of some residents should there be a particular problem with constipation/UTI (urinary tract infection) however not all. It would be very undignified for a resident who is able to use the toilet independently to be asked about this so that it can be documented.

Safeguarding Staff were documenting finding bruises/witnessing falls, however this documentation was not leading on to any changes in care plans/risk assessments. Therefore the home was failing to provide person centred care that truly reflected current needs. They were not maximising opportunities for improved independence and safety.

Ill health prevention Relevant to both physical and mental health. Apart from the fact that residents said they liked being with other people rather than on their own, their mental health was not being cared for. Chatting to residents in the lounge it was apparent there was so much personality, individuality, experience, life stories in the room and no means of channelling this. Lack of meaningful activity is soul destroying. This is what was happening day after day. Many of the residents looked unhappy.

In terms of physical health, sitting hour upon hour is physically unhelpful. Poor mobility becomes worse, ankles swell, pressure areas become more likely. The overcrowded lounge was full of walking frames making it difficult for those able to get about independently to negotiate.

2**. How were the identified health and social inequalities addressed?**

The social worker visited the care home on a regular weekly basis over a period of 9 months and this contact is still ongoing; spending time talking to residents and observing practices in the home. Reviewing progress and providing support to manager/staff in their way forward.

The social worker talked with the owner/manager about her concerns; giving information on local organisations such as University for the Third Age (volunteers visit residents in care settings to learn/study/chat), Pat dogs (volunteers who visit homes with a dog). Encouraged contact with local community. Gave examples of other ways of organising and recording.

The social worker liaised with other professionals such as district nurses and their safeguarding lead, City Council Contracts dept, Care Quality Commission, Alzheimer's society, the safeguarding trainer within the unit to provide alerter training to staff.

Arranged for manager/staff to visit another home to see good examples of person centred activities.

Attending seniors meetings to support them in working with staff. How to change their ways of working, that they need to be consistent in their approach, that they need to give praise and encouragement where it is due.

Ensuring that the home set up residents' meetings in order to allow residents to have their say and feel that they are the priority.

3**. What were the outcomes for older people?**

Outcomes: Improved choice, dignity, safety, choice. Home being run for the benefit of residents rather than staff.
Impact on well being: residents more well kempt as care provided more person centred. More choice. Residents both appeared happier and said that things were better. They said they now liked having seconds of breakfast if they wish. Better staff morale which is then transferred on to residents. One particular resident who previously had looked quite unwell, was hunched over sideways, had virtually no communication, was assisted to eat and drink is a good example. She now looks well kempt, her skin is pink and plump, she sits up right at the table and eats independently, clearly enjoying her food. She is now seated in a chair in the lounge rather than her wheelchair all the time. She enjoys watching films and bowls on T.V.
Activities now taking place, not just within the main lounge but small groups. University of the Third Age visiting for knit and natter with a small group, one to one history and internet, ipad learning with one resident. Residents seen now more as individuals with individual needs.

Some of the challenges: Working with a staff group that have a strong hierarchy and ideas of how things have always been. Involves taking apart a staff group and building up again to change the culture. Knowing who is the 'leader' and using this to the home's advantage. However staff can be misunderstood – can lack confidence to promote change, are afraid of change, are not given clear

direction and tasks, may feel that other staff pressurise them to keep active doing tasks as opposed to using time to be with residents. Also looking at the mix of staff – could there be a better skill mix.
Training implemented: dementia/person centred records: enabling staff to see residents in a different light. That the job should not be task orientated.
Limitation: sometimes owners/managers are reluctant to take on board the fact that there are areas where improvement is needed.

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