Newsletter from the National Dementia Strategy Implementation Team

Intermediate care and reablement for people with dementia living in care homes

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The National Dementia Strategy was published in February 2009 and is being widely implemented in care homes. Through monthly newsletters, the National Dementia Strategy Implementation Team is sharing ideas on how the strategy can be implemented, examples of how different homes have implemented the strategy, and resources to support care homes in their own implementation.

Intermediate care – the search for best practice

An internet search for 'intermediate care and people with dementia' generated some 90,000 links! This is a reminder perhaps of the speed of change and development within health and social care. Nevertheless, notions of reablement and rehabilitation remain primarily focused on support to regain physical capacity and abilities. There remains a strong perception that it may not be such an effective intervention for people with dementia – is this is fair?

Prevention is presented as a cornerstone of the newly published *Vision for Adult Social Care*. Alongside more personalised approaches which focus on delivering the best outcomes for people receiving care and support, a commitment to enabling people to maintain independence is a fundamental principle of quality of life. Preventative services include a range of provision intended to maintain independence including reablement, rehabilitation and other forms of intermediate care such as 'step-up' or 'step-down' from hospital. Intervening early in order to help prevent people's needs from escalating is accepted as being in the best interests of individuals and it can reduce the cost of more intensive care and support especially for health services. Is there any reason to suggest that such services are not suitable for people with dementia?

Age UK defines intermediate care as a term used to represent a range of integrated health and/or social care services that, as part of an agreed care plan, aim to:

- promote faster recovery from illness
- prevent unnecessary admission to hospital
- support timely discharge following an acute hospital admission
- prevent premature admission to long-term residential care
- maximise the chances of living independently.

It would be appropriate to add to this the idea that the intervention is time-limited. Although there is no specific mention of dementia it would seem reasonable to assume that it is intended to be inclusive. As our understanding of dementia develops it is apparent that every individual with dementia is different.

In his article below Martin Orrell refers to 'optimisation' for care homes supporting people with dementia being about working to ensure that they are enabled to enjoy meaningful lives by focusing on what they can do. He also argues that it is essential to consider the needs in a whole-person way. The My Home Life programme offers an excellent framework for best practice which ideally is at the heart of the service offered by care homes.

It is likely that intermediate care services for people with dementia will require particular skills of support staff as well as a plan that keeps moves to a minimum. Staff training and development need to emphasise that transition to a care home will require close working with relatives and carers. In my view best practice in providing intermediate care for people with dementia should set a standard that would be entirely appropriate for anyone receiving intermediate care.

Des Kelly, Executive Director of the National Care Forum

Department of Health (2010) *A Vision for Adult Social Care: Capable Communities and Active Citizens* was published by the Department of Health for consultation on 16th November 2010.
Age UK (November 2009) *Fact sheet on Intermediate Care*. www.ageuk.org.uk

Optimisation, adaptation and working to the priorities of people with dementia

When considering intermediate care and reablement for people with dementia living in care homes, definitions need to be clarified and there are balances to be struck. The term ‘intermediate care’ implies temporary interventions and the term ‘reablement’ can emphasise a recovery model, neither of which is wholly appropriate. Rather, the focus should be on enabling individuals to make the most of what they have and living enjoyable and meaningful lives – optimisation.

When someone with a dementia is in hospital and a move into a care home is being considered, it is important not to assume that the person you see before you is functioning at their best. We need to know how that person was before they were admitted and try to support them, as far as possible, to get back to this. We also need to consider the individual in the context of the particular care home – would that person be happy in that home and what effect would he or she have on the home?

Skilled intervention from care homes support teams, community mental health liaison teams and intermediate care teams can help people with dementia to move into a home or return to their care home following a hospital stay and, through early intervention in care homes, these teams can prevent people having to be admitted to hospital unnecessarily (NAO 2007).

Moving into a care home can be positive for some people with dementia and families, particularly when individuals have been living in difficult situations at home with carer stress or sometimes without basic needs fulfilled in terms of safety or having enough to eat. Once living in the home, rather than us working within set ideas about reablement, we should be adapting our approaches to the choices and priorities of individuals.

Research has identified that, while staff and family carers sometimes focus on environmental or safety issues, people with a dementia want to be empowered, to have options and opportunities, to be autonomous and to be able to make choices. While staff want to focus on helping people with dementia to regain daily living skills, individuals with dementia can be more interested in enjoying activities such as reminiscence, music and doing things with their families (Harmer & Orrell 2008).

Physical health issues are often important and physical problems should be investigated and treated. Depression is common in people with dementia and problems related to continence, mobility and falls frequently occur. Even basic things like ensuring that people have their glasses and hearing aids can improve people’s quality of life and reduce miscommunication which can lead to confusion. Activities such as physical games or gardening help people keep physically active. Mental stimulation is also important and cognitive stimulation therapy groups can useful to improve cognition. Activities should be adapted to suit the abilities of individuals the Pool Activity Level (PAL) Instrument is helpful in assessing what people are able to do and what their interests are. There are activities suitable for people at all stages in their dementia and it is important to find what is most appropriate for that individual.

Care home staff should be supporting people with dementia to maintain skills through focusing on what they could do and would like to do, whether this involves some cooking, watering the plants, laying the table or looking after the cat. Activities and activity organisers should be valued but there should not be a ‘one size fits all’ approach. People from outside the home should be encouraged to participate in daily life in the home so that it remains a part of the local community.

Martin Orrell, Old Age Psychiatrist at North East London Foundation Trust and Professor of Ageing and Mental Health at University College London.

Harmer B, Orrell M (2008) What is meaningful activity for people with dementia living in care homes: a comparison of the views of older people with dementia, staff and family carers. Aging & Mental Health. 12, 5, 548-558.
National Audit Office (NAO) (2007) Improving services and support for people with dementia. TSO, London.
Poole Activity Level (PAL) Instrument. Information at http://www.jackie-pool-associates.co.uk/index.php?option=com_content&view=article&id=100&Itemid=75

Intermediate care for people with dementia living in care homes: The Home Treatment Service in Eastern and Coastal Kent

The Home Treatment Service (HTS) in Eastern and Coastal Kent (part of Kent and Medway NHS and Social Care Partnership Trust) was set up to provide specialist *mental health* intermediate care for people with dementia. Consistent with the aims and principles of intermediate care, the HTS works with complex transitions, particularly where a breakdown in the care situation is imminent. At its core, much of the HTS work is about carefully assessing and addressing a whole set of needs, which are often severe, distressing and multiple. The aim is to bring about the most positive outcome for clients, their families and/or paid carers with a minimum of disruption and distress. This includes reducing unnecessary moves, particularly to a mental health hospital, and minimising distress should such moves be required.

Placement of the client is at the centre of decision making and intervention is paramount. The service differs from traditional intermediate care in that the HTS is for those whose primary problems relate to the dementia itself, not to physical health issues. The service is characterised by:

- person centred time limited interventions for up to 12 weeks
- multi-disciplinary team input with shared caseload
- flexible and intensive involvement
- creative risk management and
- close working with relatives and staff.

The HTS works alongside, and augments, health and social care services already being provided, reviewing their input and accessing additional services as required.

Over a quarter of our caseload involves work with clients and staff in care homes. We support when people move from hospital into care homes or from one care home to another. We also work with clients in care homes. Referrals tend to come from Consultant Psychiatrists or Community Mental Health Nurses who have visited and the homes have said they could benefit from input from the HTS. Undertaking assessment, offering suggestions and trying to demonstrate effective in ways of working with individuals, our interventions augment the care packages provided by the homes.

An example might be a person with dementia living in a care home about whom the staff are concerned because she appears to be in enduring distress or is behaving in ways which staff find challenging. We would visit to see the person and staff.

It is generally uncommon for the behaviour patterns of a person with dementia to change quickly and, when this does happen, the cause will often be a physical problem such as a chest infection, urinary tract infection or constipation, which can cause toxicity. Pain is also a huge issue. If the physical problem is treated, usually the person with dementia can regain their health. Before asking for psychiatric input, care home staff should consider initial contact or advice with Primary Care health services to exclude physical factors which may present themselves in behavioural changes.

We might use Dementia Care Mapping as a way of helping us understand the needs better and helping the care home to think about that person's needs from her point of view. Applying this learning into practice works most effectively if the manager or staff sit alongside us as we map, participating in the observation and trying to understand the challenges from an impartial observer point of view. This helps in developing a shared understanding of needs and wellbeing.

Following assessment, the Home Treatment Team (HTT) meets with the care home manager and preferably the staff to enter into a therapeutic agreement on what could be done. This might take place in a staff meeting or handover session or sometimes a meeting to discuss a particular client. Focusing on person centred care, we talk though our findings and discuss with the staff how they plan to work with that individual in the future. Crucial to the success of this is achieving a shared understanding on what needs to be done and the commitment of staff to continue to work in this way. If staff have been working to a different model to that we are suggesting, changes can be challenging to implement and, if staff feel they are being told to do things differently without understanding why or how, there will likely be resistance. Staff who have worked collaboratively with us through the assessment and the Dementia Care Mapping will be better placed to understand how we have reached our conclusions and to

continue working within the therapeutic agreement. The HTT aims to work collaboratively with staff in order that residents with a dementia can be offered the best possible care for them as individuals. The greater the shared understanding, the greater is the potential to achieve this.

The range of care providers in East Kent is huge and the resources and skills available within different services vary. Some homes are geared to people with dementia; they have dedicated time, energy and resources to help staff develop through training and promoting good practice. Some have secured good relationships with a range of NHS services including old age psychiatry, intermediate care and support for physical activity.

It is important for any service going into care homes to reach a shared understanding with the home on the purpose of the service and what can and cannot be offered. The HTS does not intervene, solve problems and leave. Rather we aim to enter meaningful discussion with staff, emphasising that 'we are all in this together', seeing the person first, understanding the difficulties and identifying together how the needs can best be met. Where good relationships exist between care homes and the HTS, staff telephone us for advice and together we can talk through the problems they are experiencing. The earlier that this shared understanding can be reached, the more successful will be the collaboration.

David Wilkie, Lead Psychologist, The Home Treatment Service for People with Dementia in Eastern and Coastal Kent, Kent and Medway NHS and Social Care Partnership Trust

References, resources and links

Living well with dementia: a national dementia strategy is now at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/NationalDementiaStrategy/index.htm

Dementia Information Portal: Resources and Links: http://www.dh.gov.uk/dementia

My Home Life is a collaborative programme aimed at improving the quality of life of those who are living, dying, visiting and working in care homes for older people. Working in partnership with the care home sector, My Home Life is undertaking a range of educational activities to assist everyone in this field to share best practice and enhance quality of care.
http://www.myhomelifemovement.org/

Quality Standard advice on Dementia from the National Institute for Health and Clinical Excellence Implementation Directorate Quality Standards Programme.
http://www.nice.org.uk/aboutnice/qualitystandards/dementia/dementiaqualitystandard.jsp

Age UK (November 2009) *Fact sheet on Intermediate Care*. This includes suggestions on working with people who have dementia. Available at: http://www.ageuk.org.uk/Documents/EN-GB/FS76%20Intermediate%20care%20Nov%2009.pdf?dtrk=true

A broad range of resources to support reminiscence are available, e.g. from Age Exchange which works with older people to improve their quality of life by valuing their reminiscences and giving them opportunities for wider appreciation in the form of visual and performance arts projects, intergenerational projects, exhibitions, publications and film. Web: http://www.age-exchange.org.uk/

National Association of Providers of Activities (NAPA) is a voluntary organisation dedicated to increasing the profile and understanding of the activity needs of older people. Information at: http://www.napa-activities.co.uk/

These DH NDSIT newsletters are compiled by Hazel Heath, Independent Nurse Consultant: Older People