Healthy Ageing in Residential Places: the HARP project

1. **Project summary**/overview of the project, timescale

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2. Background, Aims and methods

Research questions:

1) What constitutes active, healthy ageing for women and men in residential care facilities?
2) What conditions support active, healthy ageing for residents and staff, taking gender, context and individual capacities into account in providing long-term residential care?

This is an international project nested within a larger study: *Reimagining Long Term Residential Care* which contributes important background information to the HARP study. The HARP methodology is comparative, collaborative, qualitative case studies that produce data on physical, economic, environmental, social, and behavioural conditions that shape and define healthy ageing for residents and staff in specific sites. The investigation considered key dimensions of care home provision: approaches to care; work organisation; finance and ownership; accountability and the environment of care.

Data gathering

The method used was *rapid site-switching ethnography* – a relatively innovative method, designed to capture rich detail within a short, defined period of time. Care home 'sites' were selected through consultation with key informants because of their reputation for promising practices that were health promoting. Field work was organised in conjunction with the participating homes so as to inconvenience them as little as possible and to capture the everyday life of the home in as naturalistic a way as possible. Local and 'foreign' researchers worked in pairs to observe everyday practices in the public areas of the homes. Observations were conducted in shifts from early morning to late evening. Interviews were carried out with residents, relatives, staff, volunteers and others, such as visiting professionals.

We visited 14 sites for a period of a week, gathering data as described above. We also conducted 11 additional 1 day ‘flash’ visits: altogether more than 500 interviews and more than 1500 pages of field notes.

3. Emerging findings

Analysis of findings is continuing but we are confident that the following themes reflect promising practices. Despite local and national variations in practice, the principles are similar everywhere we have visited.

Three overall types of home were observed:

The care home as a **home** – emphasising homeliness

The care home as a **hospital** – emphasising physical health

The care home as a **hotel** – prioritising the wellbeing of residents as ‘guests’.

3.1 Person-centred care in practice.

Care relationships are important not only in terms of how the staff behave towards residents but also in how staff are treated by their employers. Job security for staff, as well as giving them autonomy to respond to need and make decisions can be very beneficial to both staff and residents, producing more fluid daily routines and better communication. This contrasts with routinized, task-based work that we also observed. Fluid routines were seen as most effective where there is good leadership and a shared commitment to the values underpinning the approach to care.

A good ‘culture of care’ was frequently associated with a fluid division of labour and an expectation that **all** staff, including managers, care staff, cleaners and maintenance workers, would know the residents by name and talk to them in the normal course of their work. Where managers were out of the office frequently, for example assisting with meal times, a strong sense of team work and shared endeavour was apparent.

3.2 Risk and safety

Attitudes towards risk are significantly different between North America (reflected in Canada) and Europe and some interviewees described how their attitudes had changed. Examples in Europe include open access to kitchens and tools and a relatively non-restrictive approach to drinking alcohol. In some cases, inspectors have questioned the wisdom of moves towards less restrictive decisions. Local policies on insurance and the possibility of law suits are a deterrent to risk taking but the removal of restrictions brought about very positive results in terms of resident wellbeing and was also appreciated by relatives. Policies on privacy and locked doors varied. In two Canadian homes we observed creative ways in which residents could signal that they wished to be undisturbed.

3.3 Activities

We observed a range of health promoting activities, including fit classes, dances, singing, gardening as well as Bingo and quizzes. Choral singing was common in both Norway and Sweden. The use of music varied: in a UK home music was on most of the day and used to stimulate. In Sweden it was rarely used but when it was, it was used to engender calm. In Norway it was integrated into all forms of care, with specialist staff training.

We have concluded that the most promising practices were where activities were *built in to the normal routine*, rather than being singular events. Several homes included residents in tasks such as setting tables or unloading dishwashers. Fit clubs were widely enjoyed, and sometimes encouraged residents who would otherwise avoided leaving their rooms. In a Norwegian dementia unit residents queued to use an exercise bike in the hallway, which demonstrated how useful gym equipment can be in care homes.

3.4 The environment of care

- *Residents' rooms*

There are clear differences in attitudes between countries regarding sharing rooms. Canada is moving towards single occupancy rooms but shared rooms are still relatively common. In Sweden the normal arrangement is for a resident to rent an unfurnished 'apartment', which has its own en suite bathroom and small kitchenette. Hospital beds are used to protect staff health but otherwise the furniture and decoration is the resident's. Single occupancy is the norm in Norway, Sweden and the UK. We did, however, encounter occasional situations in dementia care in the UK, where managers had successfully placed residents together to improve their mental health.

- *Design and decor*

Non-restrictive environments were important to health, including for residents with dementia, circular walkways and access to safe outside spaces. Good design did not always work out in practice, such as in a garden with paths too narrow for wheelchairs. Breaking down physical barriers between staff and residents, such as inaccessible nurses' stations, enabled relationship building and good communication.

Colour schemes varied, although bland colours were dominant. Advice on colours suitable for residents with dementia produced soft colours in a Swedish home but bright and stimulating colours in a UK home and Norwegian, with quantities of 'rummage'.

- *Gardens*

Gardens, including 'sensory gardens' were a major source of pleasure and a great setting family visits, picnics and walks. A prizewinning garden in Sweden was open to the public so that school children and toddler groups visited. Without sufficient staff, however, this would not have been such a benefit to the home as

residents had to be accompanied. In Canada we observed a Japanese garden, tended by residents.

3.5 Food and dining

Fresh food, cooked on site was more promising than the practice of contracting out catering arrangements which was increasing in Canada. As was observed: in Canada food is more about nutrition; in Scandinavia it is about meals. The nutritional aims were not always achieved: in one Canadian home we observed how each tray of food was carefully prepared to comply with individual dietary needs but there were insufficient staff to ensure the resident actually ate their meal.

The most common arrangement was for about 20 residents to eat restaurant style in a dining room at the same time. Exceptions were where residents chose to eat alone in their rooms. In one of the Swedish homes 8-10 residents ate lunch and dinner together, family style, around a large table or around a couple of smaller tables. Arrangements for help with eating varied: in most settings help with eating was part of the care staff's job description but staff in some Canadian homes relied on personal assistants, relatives and volunteers to help. Some homes had cafeterias open to the public, which could enhance residents' social lives.

3.6 Staffing and personal assistants

In almost all the homes we visited, there was evidence that staff were working intensively and in some that their workloads were very stressful. On the other hand, higher staffing levels did not necessarily benefit residents where they did more administrative rather than care work. Some homes were considered very good places to work, despite the workloads. Length of service can be an indicator of job satisfaction and in some homes rarely used agency staff because staff preferred to cover for absent colleagues or they had a regular part-time roster.

In Canada, the employment of personal assistants by residents' families is not uncommon. PAs are supernumerary and can improve the resident's quality of life. There are negative outcomes also, seen in inequalities between residents and uncertainty about the allocation of responsibilities between PAs and employees.

3 Conclusion

Ongoing analysis will enable us to draw stronger conclusions about the relationships between the broader national contexts and the particular homes that we observed and to highlight the nature of the links between staff wellbeing and resident wellbeing. As we chose to study homes that had been recommended, it is unsurprising that in each we observed promising, health promoting practices. Our findings challenge the often promoted idea that small is better because it is more homely. Indeed, not all small homes we observed were homely. Larger homes offered activities that would be unaffordable in a small home and often

better staff protections. Moreover, they can be organised into smaller units that can generate the advantages of large size while avoiding problems of institutionalisation.

A broad view of health is important to overcome a preoccupation with the physical and enable a richer lifestyle for residents that is less uniform and includes a degree of risk. A strong culture of care that is accepted across all individuals involved with a care home can generate a positive, health promoting place to live and work.

4. Thanks are due to the residents and staff at the care homes and others who participated in the field work, as well as to the key informants that assisted in the early stages of the project.

For further information please contact members of the team using the contact details above.