



RSAS Age Care

The Teaching Care Home

an option for professional training

**The proceedings of a joint
British Geriatrics Society
and RSAS AgeCare conference
held on 11 February 1999**

Foreward by

Professor Sir John Grimley Evans

Although, at any one time, less than 5% of our older fellow citizens are living in institutions, this figure greatly under-estimates the impact of institutionalisation on our lives. Most of us will die in an institution and of those of us who reach the age of 65, one man in seven and one woman in three will spend a year or more in an institution before dying. There are also reasons for expecting these proportions to increase.

Background

Geriatric medicine began in long-stay institutions but for the last thirty years has been devoting most of its time and energy to keeping people out of such places by providing more and better acute and rehabilitative care. In the 1980s, Government policy took most long-term inpatient nursing care out of the NHS into the independent sector. Although this offered patients and their families more choice, the political motivation was to shift the costs from the free-at the point of delivery health budget on to the means-tested social budget. With money as the central concern of both the providers and customers of the system, quality has been threatened from both sides.

There has never been a 'Golden Age' of institutional nursing care in the UK. Successive reports from the Health Advisory Service made it clear that geriatricians varied widely in the quality and frequency of their input to their long-stay wards. Although nominally subject to the standard-setting and surveillance of the NHS many long-stay hospital wards were dismal and heartless and they were always at the end of the list for upgrading or redecorating. There were also well-publicised scandals in social services residential homes where some Councils seemed more concerned with the comfort of their employees than of their elderly residents.

Regulation

It would be unjust to suggest that neglect and abuse are any more common in our system of devolved long-stay institutional care for older people. There is, however, concern that present forms of regulation do not give proprietors and staff of Homes sufficient support in setting and raising standards. Indeed industrial psychology suggests that regulation is the wrong way of going about things. People do best when working for their own self-respect and job satisfaction rather than merely meeting lists of rules or preparing for occasional visits from overworked regulators.

R&D in long-stay care

There is also the problem of research and development in long-stay care. We do not know, for example, how to

assess the feelings and quality of life of people with dementia or aphasia. We do not know enough about non-pharmacological ways of responding to challenging behaviour. There are unsolved problems, for example, in nutrition, maintaining mobility, and preventing boredom. More basic issues arise in the organisation of care, and in the reconciliation of conflicting priorities. Homes that are the happiest may not be the tidiest or the least unruly. Because of other preoccupations, academic departments of geriatric medicine did little research in their long-stay units when they had them. The units were also too small for meaningful work. Now there is no research and development structure for long-stay care.

Joint enterprise

As a response to these issues, the Teaching Care Home initiative is a joint enterprise from geriatric medicine, social work, and the charitable and private residential and nursing home sectors. The initiative was launched at a symposium at the Royal Society of Medicine on 11 February. During the day's proceedings it became clear that we brought to the symposium several different tentative models of what a teaching care home might look like, and were fortunate in being 'warned off' some of them by Professor Robert Kane's account of unsuccessful experiments in the USA.

The way forward

By the end of the day most of us were seeing a clearer way forward. If we are to influence care, rather than just publish papers about it, each geographical district needs not just a single Teaching Care Home, but a network of collaborating Homes spanning the statutory, charitable and private sectors. There will need to be a co-ordinating centre and in University settings this could ideally be a purpose built Home affiliated to the academic department of geriatric medicine and with multiprofessional teaching and research faculty. Formalised training programmes should be provided that match realistic job descriptions for all grades of nursing and residential home staff. Cooperative research and development will need to be organised across participating sites. That participation is crucial and thought must be given to making explicit the value added for proprietors, staff and residents from collaborating in a Teaching Care Home network. There can be little doubt that supplanting a regulatory framework by a research-based culture of self-evaluation will be of benefit to all. We must convince Health and Social Service managers and the Government of this, and to that end it is to be hoped that geriatricians will give the initiative their wholehearted support.

The Teaching Care Home

Over 100 people attended a meeting on the concept of the Teaching Care Home held at the Royal Society of Medicine on 11 February 1999. The meeting, organised jointly by the British Geriatrics Society and RSAS Age Care, and sponsored by BUPA, included an audience drawn from a diverse range of professionals with an interest in long-term care, i.e. geriatricians, GPs, nurses, health economists, carers, politicians, academics, nursing home administrators and

representatives from the charitable sector.

The meeting was introduced by Dr John Wedgwood CBE, Chairman, RSAS AgeCare.

Sir John Grimley Evans, Professor of Clinical Gerontology, University of Oxford, chaired the morning session, whilst Oliver James, Professor of Geriatrics, Newcastle University, chaired the afternoon session.

**DR JOHN WEDGWOOD AND
DR ARUP BANERJEE, PAST PRESIDENT,
BRITISH GERIATRICS SOCIETY**

Introduction

The transfer of frail elderly and disabled people from long-stay NHS hospital wards to the charitable and private sectors for long-term care has brought many advantages but some drawbacks. It has improved the autonomy and privacy of residents and their accommodation but prompted worries about loss of provision for the training of care staff. The development of training programmes and research projects, vital for improving care of residents, has tended to be left behind.

The establishment of Teaching Care Homes is one way of addressing this problem. Several of these operate in the US. The concept is relatively new in the UK but is already gaining the attention of many concerned with long-term care.

The idea itself of using nursing homes for undergraduate and postgraduate teaching is not new. In countries where geriatrics is not recognised as an acute specialty, nursing homes provide the base for specialised training in geriatric medicine.

In this country, specialised geriatric medicine has always been mainly hospital-based with access to the facilities and resources of adult medicine. Over the last 10-15 years, however, there has been an enormous and uncontrolled proliferation of nursing homes run by the independent sector and the virtual disappearance of long-term care from hospitals and local authority provision.

The practice of geriatric medicine is changing fast - much of it for the better but, in quite a significant part, for the worse. Whilst older people with single organ disease are receiving better care with easier access to

high technology diagnostic medicine and therapy, the elderly with multiple problems and chronic incapacities can no longer turn readily to a truly dedicated specialist in the complex area of old age pathology and multiple system medicine.

Today most of the medical care of chronically sick and frail elderly people with multiple pathologies and disabilities is undertaken by GPs in private nursing homes. Specialists in the field are no longer involved. In consequence, not enough specialist training, teaching or research work is being pursued in this area.

These issues concern leaders of the geriatric medical specialty and were the focus of discussion at a specially convened meeting in 1998. As a result, the present meeting was planned to widen the debate amongst others concerned with the various aspects of nursing home management and care. It is hoped a body of ideas will emerge that will launch an academic nursing home movement in the UK and ultimately generate a blueprint for a model Teaching Care Home.

**KINA, LADY AVEBURY,
CONSULTANT ON MENTAL HEALTH**

The needs of frail patients

Active proposals to demonstrate how best to promote and deliver quality training in long-term care need to be disseminated far and wide.

The need for training is universally acknowledged but receives low priority when budgets are stretched.

The Centre for Policy and Ageing (CPA) is likely to reflect this need in its latest policy document commissioned by the Department of Health and the

Welsh Office to include a set of national required standards for continuing care for older people across England and Wales. These will be basic standards and will be robust, measurable and enforceable. The CPA has focused on the needs of very vulnerable people because they are most subject to faults in the system.

In the CPA's document on standards, quite modest proposals are recommended for training to the effect that, by the year 2005, half the staff in residential care homes should have Level 2 NVQ. In nursing homes there must be RGNs, but training is just as much about attitudes and values as specific nursing skills.

Perceiving residents as customers rather than patients is very important and takes account of their rising expectations. Currently, there is a perceived lack of information as to what residents can expect from care staff. Conversely, care staff frequently do not know what is expected of them. The lack of training is evident and is needed at all levels.

We are moving towards a point where the distinction between nursing and residential care homes is going to disappear. As a result, we must be careful to move towards developing a holistic multidisciplinary approach to training whilst not discarding the absolutely essential basics of healthcare training.

The Teaching Care Home offers the exciting prospect of academic high quality training being offered in the workplace setting where it will be applied.

MICHAEL CORP, CHIEF EXECUTIVE,
RSAS AGE CARE

The Concept

Training in long-term care has hitherto tended to be fragmented and has had more to do with the enthusiasm of individuals and organisations rather than a co-ordinated attempt to ensure staff are trained up to benchmark standards.

Within the caring profession, long-term care has been regarded as a low priority, low prestige, area on the periphery of professional training, despite the huge numbers of people involved in it. Training programmes in Teaching Care Homes will hopefully reverse that view.

A physical model for a Teaching Care Home could comprise 50+ beds to provide the range of experience required in an economically viable unit. This could be broken down into smaller sub-units in which people could begin to develop a sense of ownership. Within the unit would be a social and therapy day centre, used

by an outreach team for people in the community as well as by the residents within the home, on an equal basis.

Finally, there would be a teaching unit with lecture and seminar rooms and library facilities.

The educational model aimed for in the Teaching Care Home is a linking between different specialties within the sector by education. These would include pre- and post-registration medical students, GPs, nurses and gerontologically trained nurses. Support for the higher level of NVQ would include a benchmarking of standards for practical experience. Training would also be included for therapists and for staff concerned with providing the hotel services; quality food, good housekeeping and nice rooms heavily influence quality of life for residents in care homes.

Training in good nursing home management is also essential especially for managers coming from the nursing profession, who lack organisational experience.

The philosophy of the Teaching Care Home is all important; it has to be resident-centred - not run to suit the care staff - and must seek to optimise the quality of life and independence of individuals while maintaining their links to the outside world. Teaching and research are subordinate to this philosophy and may not compromise it.

DR CLIVE BOWMAN, PHYSICIAN &
GERATOLOGIST, INTERNATIONAL INSTITUTE
ON HEALTH & AGEING, UNIVERSITY OF
BRISTOL, BUPA CARE SERVICES

An opportunity for the UK

The nature of geriatric medicine is changing. Patients are now surviving previously fatal illness through medical technology and are presenting with patterns of need for which many staff are poorly trained to manage.

Nursing will remain the lead profession in long-term institutional care, and its professionalism and interaction with medical staff care assistants and other support services are crucial to the construct of care. Regrettably, process regulation, rather than the encouragement of optimum outcomes, principally govern most staffing issues at present.

The teaching nursing home offers a number of opportunities, as follows.

- ◆ The training of medical students, and post graduates both for primary and secondary care, particularly, in aspects of chronic disease management. The speed of throughput in efficient hospitals has rendered the biography of disease elusive to trainees,

and rehabilitation, long-term and palliative care are increasingly undertaken in the community - again beyond the ready access of trainees.

- ◆ A new cadre of geriatricians is required for the development and management of care pathways and clinical guidance, particularly in the context of clinical governance.
- ◆ General practitioners who will be providing the core of medical care need training in assessment and interdisciplinary working as well as exposure to multiple pathology and chronic disease management; in particular, understanding rehabilitation opportunities, prescribing, in situ care possibilities, and palliative care are all fundamental.
- ◆ The gerontological nurse specialist proposal needs a special form of training that will equip nurses to become responsible senior professionals in assessment processes, and home management for intermediate, rehabilitative and palliative care. Trained gerontological nurse specialist could be expected to have particular competence in training care assistants.
- ◆ A development of the NVQ system, perhaps. The Joseph Rowntree Foundation's certificate in care is required for what we recognise today as the "Level 3 NVQ care assistant", capable of further training to become an RGN or, perhaps, a Care Home Manager. An appropriate, non-contentious term is required to further enhance this exciting development.
- ◆ Research and development in care is in need of considerable development. It has suffered from being in the 'no-man's land' between technological medical endeavor and the social care domains.

There are some positive examples of training within care homes, for example BUPA Care Services have a Professional Development Centre that, over the last few years, has seen 192 nurses complete SEN conversion to RGN (with another 126 presently in training) and some 1334 ENB courses completed. Partnership action in training should become a central component of commissioning.

JEF SMITH, GENERAL MANAGER,
COUNSEL AND CARE

The Residents and their Advocates

Systems designed by professionals for consumers do not necessarily match the needs of the latter. If we claim the interests of consumers are central to a Teaching Care Home we have to be careful to see they are truly served.

There are three elements in the Teaching Care Home that require particular consideration from the consumer's viewpoint.

1 The importance of communicating best practice

through teaching and research.

These are different processes from care and may be in conflict with best care, despite a teaching care home being a centre of excellence. Teaching and research need to be conducted with sensitivity, with intrusiveness kept to a minimum, and with thought given, particularly where Alzheimer's patients are concerned, to issues such as continuity of care if there is to be a constant throughput of staff.

2 The concept of demonstration

Teaching Care Homes have a role as models for other smaller care homes. What is needed is a general improvement in quality across the board, not just in isolated teaching homes which have been the focus for investment.

The problem for the immediate future will not be establishing certain homes of very high quality but in bringing up the generality of homes to a basic level from a pattern of mediocrity.

3 The aspiration to excellence

We are still struggling to define what constitutes a model home because excellence is multidimensional. The concept of awarding star ratings from a consumer perspective would also be difficult to apply because residents differ in their preferences and some would be happier in one sort of home rather than another.

We have made great strides in improving conditions for residents in terms of privacy, individual space and comfort. We still have further to go with flexibility to accommodate individual requirements and in the provision of a greater variety of stimulation than a TV in the communal lounge.

The overriding consideration behind the Teaching Care Home from the residents' point of view is whether the capacity to teach, conduct research, and demonstrate excellence will still leave residents' care as the central focus of concern. If it does, it will be a success.

PROFESSOR ROBERT KANE,
UNIVERSITY OF MINNESOTA

The American Experience

The idea of making nursing homes a model for teaching professionals came from teaching hospitals. The model has since gone through six variations because different organisations have adapted the idea in their own fashion. The National Institute on Ageing (NIA), The Robert Wood Johnston Foundation and several large chains of nursing homes launched their own models of teaching homes for their own purposes. Medical schools have used the term Teaching Nursing Home in

a number of different models and there have been some self-supporting centres set up primarily for research in this area.

1 The NIA model

This became more a series of research projects focussed around the elderly in long-term care, but half were laboratory-based. Some clinical studies were done, not necessarily in a nursing home setting, some studies were multidisciplinary and some involved very basic research with animal models.

2 Robert Wood Johnson Foundation

A series of projects funded in the early 1980s involved the Foundation contracting with a number of nursing schools to enter into close relationships with selected nursing homes. The object was to enable an interchange between the faculty of the schools and the staff of the nursing homes. What emerged was a particular focus on the use of nurse practitioners playing a more active role in the primary care and oversight of nursing home residents. This produced a series of research projects that have certainly changed the thinking about how to deliver better care to nursing home residents but did not unfortunately lead to sustained affiliations once funding was withdrawn.

3 Large chain corporations

These took a marketing approach and tried to develop a positive national image of their nursing homes with provision of facilities that enabled them to affiliate to academic centres. They supplied support for the faculty, supported training of advanced students or research fellows, and provided funds for research. This continues in some centres where they have evolved a good reputation.

4 The Medical School Model

This emerged as a method for extending the medical school faculty by establishing contractual relationships between the geriatrics department and nursing homes so that geriatricians work part-time as medical directors for the homes. Their responsibilities cover quality assurance, structural and administrative tasks, and overseeing the medical staff employed in the homes. Faculty members would also be the predominant providers of medical care to individual patients in the homes, which would then become training sites for fellows or post-residency physicians and sometimes medical students.

In some cases, the arrangement might serve as the basis for clinical research in which projects were undertaken either by the research fellows or faculty themselves.

A variant of that approach is one where the faculty performs the same functions but without the contractual relationship where the home pays for their services as directors.

5 Self supporting research organisations

These do not occur very frequently but there are some places which have launched their own base for research within long-term care facilities usually using

funds from an endowment. One example is the Hebrew Rehabilitation Center for Ageing and another, The Philadelphia Geriatrics Center. They then compete for funds, contracts and grants as happens with departments within a university. Some staff have a joint appointment with an academic centre. The difference here is that the locus of activity is within the long-term care facility rather than being based in the university with people coming in to the home as outsiders.

Both the examples cited have made substantial contributions to the field and changed the nature of facilities where they are located.

Lessons from the US experience

1 Ethics

When conducting research a number of difficult ethical considerations have arisen, such as the problem of obtaining informed consent from people with no short-term memory. Most research has been confined to clinical issues without giving much attention to the basic elements of nursing home care. But if the ultimate goal is to look at the impact of nursing home care, the focus needs to be on the context of the environment and what effect this is having on people's lives.

2 Typecasting

One of the great pitfalls when teaching students is to equate long-term care with nursing home care. Long-term care then becomes defined as something that takes place in a nursing home, whereas we could be looking at a much broader spectrum of possibilities for offering care and support.

3 Lack of representativeness

One has to be careful not to teach students about ageing with reference only to a subset of very frail older people living in nursing homes who are unrepresentative of the broad spectrum of older people. This would be akin to teaching someone about children by showing them only children on a paediatric hospital ward.

We also have to guard against seeing older people only as useful teaching material, while ignoring their humanity.

4 Research

Applied clinical research should look at better models for developing care. There is a fundamental belief that no variation in nursing home care will make any difference to individuals. But a small aliquot of good treatment could make a larger difference here than in any other part of the health system. A growing body of empirical data shows the benefit of good care, e.g. randomised clinical trials of rehabilitation procedures show dramatic benefits are possible in functioning. Better preventive primary care has the capacity to reduce the level of hospital admissions and reduce costs. Better nursing care, with improved management of urinary incontinence, skin maintenance and active mobilisation has the potential to prevent deterioration

and demonstrate benefit.

The architectural possibilities of nursing home design have not yet been explored. We need to challenge our knowledge of design, texture and colour to see how we could improve autonomous function amongst people who are cognitively impaired.

We need to develop better outcome measures; we are fixated on process and structure in long-term care. And we need to measure quality of life. Only when we measure outcomes well and use them as a basis for accountability will we create an environment that will allow us the flexibility to be innovative. In most cases of long-term care, the goal is not to make people better but to slow the rate of their decline. To measure that you first need to know the expected rate of decline. Measurements can then be used to drive the system as the basis for care planning and internal accountability.

For example, the effects of special management programmes, such as those for segregating demented people, require proper evaluation. So far, they have been shown to be more expensive without being any more effective. Unless we can match empirical work with the fervour of belief we are going to find ourselves in outmoded models of long-term care.

5 Education

We need to develop good role models of primary care, show how to use time effectively, and how to link primary care providers with other members of the nursing home staff. We need to develop jointly shared goals and get students interested in communicating with older people and improving quality of care. Students could participate in audits and become actively involved in team projects and case studies.

We want to move away from the apprentice model and try to broaden students' horizons so that the next generation can do a better job than the current one.

Very few of the Teaching Nurses Homes have been successful at developing interdisciplinary models. Although several have developed multidisciplinary models with representatives of a variety of disciplines training their students, there are as yet no models where you can see new mixes and effective collaboration, either within the health system or across the social and health systems.

Conclusion

Few of these nursing home programmes have been effective in changing the nature of nursing home care in the US. The goal of the Teaching Care Home is defined as essentially developing, testing and disseminating the art of the possible; stimulating people to think beyond the here and now. We have not explored the possibilities of what long-term care could or ought to be. The presence of intellectual outside forces could stimulate new developments in the field and subject them to necessary empirical analysis. The UK is taking an interest in US models of Teaching Care Homes but

the difference in traditions and culture suggest it might be best advised to innovate rather than imitate US versions.

PANEL DISCUSSION

Professor Sir J. Grimley Evans

One of the research themes in British nursing homes relates to the non-pharmacological ways of managing challenging behaviour. How is that tackled in the US?

Professor Robert Kane

Avoiding the use of physical restraints where possible is built in to the current regulations. There is also a strong faction campaigning for the abolition of bed rails in the face of considerable opposition from some residents and relatives. A reduction in psycho-active drugs was also built into the regulations and there has been a sharp decrease in their use. Unfortunately, there has not been a concomitant improvement in the appropriate use of psycho-active drugs, particularly antidepressants. Regulation is a crude way to change an industry; it does very little to improve the overall quality of care. The US is a country which has heavily invested in regulation and payment as primary tools of restructuring. The belief is that either of those will provide incentives to change care, but what they do is provide incentives to deal merely with meeting regulations in order to obtain payment.

Clive Bowman

One of the problems in funding medical research is that most of the grant giving bodies require strict standards of protocol. The interdisciplinary developmental work needed in this field doesn't comfortably fit in the context of a lot of grant-giving agencies. There are some observational studies and natural trials that can be cited but the funding for proper work of this nature is not very substantive. The Newcastle system for haematology, for example, where innovations can be trialed against population databases, would apply extremely well to populations of elderly frail people in care.

Professor Robert Kane

The lesson is that, on the one hand, we need to be sensitive to intuition and to make sure we capture that in formulating our interventions. But when it comes to testing interventions we need to hold to strict methodology because this is an area that has been dominated by strongly held beliefs. Double blind studies

may have their limitations but they are better than being guided merely by fervently held beliefs; the latter do not represent truth. Coming from a country that makes policy on the basis of consensus conferences, I can say there is a great deal of difference between getting agreement and what is actually correct. The way we choose to evaluate this kind of work raises some very important issues but unless we evaluate it properly we have the potential to do great harm and we run the risk of giving greatest credibility to those who are the most persuasive, rather than those who are correct.

Professor Tony Warnes

Speaking as a medical educationist I am forming the view that nursing homes are not the best place to teach good nursing home care. There will be too many incompatibilities and the care of the residents will be distorted too much by the teaching function. The model that might be preferable is for the teaching unit to be based next door or in a higher education institution and for students to have a diversity of placements and work experience periods in a variety of homes.

Professor Robert Kane

I think your concerns are justified but it seems to me what you are looking for is not the harnessing of a typical nursing home to become a teaching site. There has to be an active partnership and a mutual commitment to create something that is better than what exists right now. Having taught a large number of students in different settings, I can say that students learn best where they see positive role models. One of the failures of the US medical school system is that it taught a level of care that is unreproducible in general hospitals.

We have to be careful, if we want to make this a positive learning experience that is going to produce a new generation of positive practitioners who are going to be more skilled than us, that we find those exceptional places that are on the leading edge and will develop the right environment. It may be that this will come at the cost of disrupting some of the lives of the residents and they need to be involved in actively deciding whether or not they are willing to go to a place where this will happen. That is part of the price you pay to go to a place that is aiming for excellence. We must not become so limited by these constraints that we do not advance the field.

Jef Smith

Professor Warnes has a point at least where it comes to size. It may be that the demands of training and research on the one hand and care on the other hand are not just incidental but are fundamental and cannot be brushed aside. We know the future population of homes will be concentrated on dementia and we know people with dementia do best in environments where they have relatively small numbers of people with whom they need to interact. There are parallels with homes

for people with learning disabilities where it would be unthinkable to consider 50 or more places. Yet in the field of old age care we are still producing nursing homes of two or three times that size. There is an urgent research agenda there with regard to optimal size and it may be that it would wreck the concept as it is currently conceived.

Stuart Parker

Is there any consensus among the panel regarding what the problem is to which the Teaching Care Home provides a solution?

Professor Kane

The problem we have is that in the term "the nursing home" we have a misnomer since we are providing neither nursing nor home. The challenge is to identify ways in which we can begin to provide care for frail elderly that will allow them to live out the rest of their lives in a situation that will maximise the quality of life they enjoy and at the same time preserve their functioning to a level that is realistically possible. In some of the examples that we have cited today there is at least a strong belief and some pretty good epidemiological data that suggests in many cases we are doing more harm than good. We are overmedicating people, we are overlimiting them and imposing constraints and restraints that would be unfathomable in other walks of life.

We are also thinking in enormously constrained ways. For example, when we look at size as either too small or big we are ignoring all sorts of potential for modular design and other ways of gaining economies of scale while providing for abilities to adapt to the needs of individuals and maintain a personal sense. Many people live in very large complexes - in single homes in large developments - and maintain a very high level of personal life. We have not been nearly creative enough in this area. The problem we are addressing is essentially the lack of creativity, a shortage of innovation, the potential for premature regulation and restriction of options, a preoccupation with structure and process as opposed to outcomes, and a failure to define and measure the outcomes we wish to pursue.

Kina, Lady Avebury

The problem at the moment is there is still a perfectly appalling lack of training, and too much ignorance and insensitivity shown by people in the care industry about the people they are caring for.

Arup Banerjee

I believe we are not doing a very good job at the moment. I think this concept would provide us with a better knowledge base which could be disseminated to others, it would help raise standards and delivery of care and

improve the lot of some very vulnerable people.

Jef Smith

I think one of the common strands is the issue of professional roles and status. There are three occupational groups. In the social welfare field the status of practitioners working in residential care of the elderly is very poor with lower remuneration than shelf-fillers in supermarkets. Attempts to improve that in terms of training are still rudimentary. In nursing the issue is one of staff who are qualified in nursing but in traditions that have very little to do with the care of elderly people in residential settings. In medicine, geriatrics as a specialty has been frozen out of the residential and nursing home field in the past decade and if this is a way of getting back some expert medical attention into the care of elderly people that would be interesting.

Michael Corp

Training in this field is unfocussed at present. One argument for the Teaching Care Home is that it provides a focus that starts to bring disciplines together to think collectively.

CAROL CAPORN, DIRECTOR OF SOCIAL SERVICES, RICHMOND

The Social Services contribution

The way in which social services helps older people choose the way they live out the ends of their lives is through a range of processes in which their care needs are assessed and matched against what we can provide through the public sector. Choice is considered as far as possible.

Social services want to know how a Teaching Care Home is going to get on the approved list of homes, what contract specifications can be made, how much it will cost and how the charging policies are going to work across free NHS care and private residential charges. We want to know what quality assurance systems are going to be in place and how these will match with user outcomes. Quality is measured through outcome assessments for individuals, which enables comparisons to be made among service providers.

There are numerous scrutinies on the way, joint reviews and national frameworks in addition to the CPA standards review which will drive how social care is going to be delivered, financed and planned for the future.

Certain values already guide the planning, purchasing

and provision of services to elderly people which safeguard their fundamental human and individual rights. The Social Services network is complex and is being modernised according to a Government White Paper which sets out an agenda for the next decade (see *March BGS Newsletter*). Within that there are clear imperatives about promoting independence of people, protecting them, getting value for money and delivering safe and effective work forces. There is also an emphasis on trying to find new solutions to old problems.

Where the Teaching Care Home fits in and how it functions as a teaching environment is not yet apparent. It is not yet clear how it will demonstrate adherence to the values sought by Social Services, i.e. promotion of independence, protection, equal opportunities and the development of holistic assessments.

There is a growing emphasis in the housing market about the different ways of providing care and using community facilities that could spell the end of residential care. There are policies driving us away from permanent care into prevention, rehabilitation and care in a person's own home. This is very expensive and has to be balanced against the option of residential care. Resources are severely limited and it will be a challenge to develop any new initiatives in the long-term care field.

Training is under review in social services with new occupational standards frameworks, qualifications and awards. There is a debate with regard to managers of residential care homes as to whether the management training qualification should be a diploma in social work or an NVQ level 4. This needs to take into consideration what training should be required for managers if nursing and residential care homes merge.

Guarantees of public protection will come from the setting up of the General Social Care Council which will require proof of qualifications from staff before they are allowed to register and work at a particular level.

There is an enormous amount of pressure about human resource strategies which health and social care agencies have to work out together to build skilled workforces who can work across boundaries.

Professor Brocklehurst

Could a Teaching Care Home contribute to the training of social workers and care assistants or will it be biased towards medical and nursing students?

Carol Caporn

Training for social care and medicine is currently going in parallel streams. Ways are sought at all levels for engaging in mutual design of some of the courses. Some medical schools are now working from a community model. Discussions need to go on in the

new training council TOPSS between those planning clinical training and those planning social care training so they can design modules with some overlap. If it does not happen at that level I believe we will be turning out people who look through particular blinkers at the job they do. At a local level, it is about engaging in seminars and other activities throughout training so different layers can address the problem of communicating across professional boundaries where we have a common interest, while recognising we have discrete areas we wish to pursue alone.

DR BRENDAN MCCORMACK, HEAD OF PRACTICE DEVELOPMENT AND CO-DIRECTOR RCN GERONTOLOGICAL

Training nurses

All the education, training and learning that would take place in a Teaching Care Home is built around a core philosophy of gerontological nursing geared to empowerment of individuals through a re-enablement approach - trying to maximise an individual's potential, however limited that might be.

The gerontological nurse specialist chooses to work with older people, is highly skilled and is able to work across care interfaces. We are about to launch a curriculum for gerontological nurse training in January 2000. Specialist elements of the curriculum will include ways of developing a set of implicit standards, values and moral attitudes and exploring power dynamics.

Gerontological nursing aims at being person-centred by looking at people's core values and how these are manifested in conducting their lives in a care setting. It is called saliency - seeing the most pertinent issues - which comes from knowing a person and perceiving the deeply embedded values that drive them. It tries to maintain care of the whole person rather than focus attention on bodily concerns. In the medicalisation of old age, person and body tend to be disengaged. The body becomes looked upon as a thing separated from the person that is worked upon.

This approach can only develop within a culture that enables such expertise to flourish. It will not be achieved by going into classrooms away from the care context. It can also only happen when nurses are given authority for their practice and are accountable for it.

Therapeutic relationships have got to develop between team members as well as with residents and that requires cultural change and changing attitudes.

We are challenging the current approach of educating

nurses for work with older people changing the emphasis from theory to work-based learning practice. A Teaching Care Home could foster that philosophy. It will not achieve this by building care homes with teaching units attached to them but by creating supportive and challenging care environments and by creating cultures where practice is challenged and constantly re-examined.

The TCH should be innovative and practice-oriented, have a developmental and evaluative approach and be multidisciplinary. Resident involvement is central to it, as is consultancy - a means of sharing expertise gained in good practice throughout a locality.

LYNNE PHAIR, NURSING AND CARE MANAGEMENT ADVISER, RSAS AGE CARE

Training the carers

The quality of carers and their education depends on the quality of those who lead and teach them. Therefore, the Teaching Care Home should be teaching the teachers. Well-functioning ordinary nursing homes that already exist as multidisciplinary establishments should be designated Practice Development Nursing Homes (PDNH). Everyone working in the PDNH should be trained and educated according to the basic concept. There should be core modules that everyone studies about attitude and philosophy, basic health and safety, quality assurance, health promotion and understanding the needs of the residents. On top of that come the specialist modules for each discipline.

A second approach acknowledges that long-term care does not just happen in nursing homes. Care teaching could, therefore, take place in an educational centre where teaching for all disciplines can be co-ordinated and staff from the Nursing Home unit may be part of the teaching team. The residents will not, however, be automatically available to be 'taught on' in the traditional way.

Specialist education would include modules and courses from Level 2 to M level in all disciplines - medicine, gerontological nursing, management, leadership training, catering, hotel services, social work, professions allied to medicine and administrators. Teaching within each discipline would be geared to the application of professional skills to the needs of older people.

All staff who are not directly concerned with care should have initial training to help them develop sympathetic attitudes with sufficient knowledge and understanding of the care philosophy. They should also be aware of any aspects of their own work impinging on the care of

older people. For example: administrators should be able to advise residents about social security entitlement; housekeepers should know about infection control measures and choosing furnishings and crockery suited to the needs of physically frail residents; and chefs should be able to design light but highly nutritious meals suited to small appetites. The total care "package" will be a truly disciplinary attempt at helping and supporting the older person in receipt of long-term care.

**DR PHILIP RAZZELL, GP
SEVENOAKS, KENT**

Training the Primary Care Team

The transfer of frail elderly people from secondary to primary care has led to a vast increase in the numbers GPs now look after in care homes. GPs are having to invent systems, standards and ways of coping with the greatly increased workload. They experience problems caring for people with multiple pathologies, often receiving multiple drug prescriptions and at greater risk of experiencing adverse drug reactions and interactions. GPs are often called in inappropriately at times when nursing home staff are under pressure because morale is low, sickness absence is high and agency staff are drafted in who do not know the residents and feel unsupported.

It is difficult to establish consistent standards where GPs from several practices attend the same home. Unless the GP has a sufficient number of patients, it is difficult to visit regularly, and there is frequently antagonism between GP and care staff. Assessment, care and review is largely unstructured and unsatisfactory.

Some GPs are being appointed as Visiting Medical Officers (VMOs) by health authorities or trusts with a greater role in setting standards, assessment, formulating individual medical management plans and conducting reviews. However there is no specific training for VMOs and there is a tremendous need for more education in the field of elderly care for all members of the primary care team.

Teaching Care Homes could have a role in training VMOs as well as medical students, nurses and care assistants. There is a dearth of published information on what should be the standard of medical care in Homes. We need examples of good practice in action. However, setting up a few prestige projects may be less productive than nurturing a number of small improvements on a wider scale. Setting up model Teaching Care Homes as centres of excellence would place an extra burden on staff working in them to teach

and perform in a certain way that may not be typical of or relevant to the way nursing is carried out elsewhere. An 'all singing, all dancing', academic fun palace may not be the ideal way to improve care and education overall.

The virtual teaching care home

A better solution, that would meet many of the aims of the Teaching Care Home, may be to get all existing care homes, hospital services, primary care services and educational institutions within an area to cooperate together on a teaching care programme - a virtual teaching care home, supported by an IT link - that could be totally integrated within existing healthcare structures without actually having to build a new centre. The building task would be the integrating - putting people in touch and getting them to work together towards the common goal. It would be an exciting and practical project that would involve multi-agency and multi-disciplinary working, with patients and residents as the focused end-point of our efforts. Medical schools, postgraduate medical education centres, nurse training and NVQ courses for care staff would all be included and there would be links with the local district general hospital, departments of geriatric medicine and group practices.

It is conceivable that within the next decade we might see care homes linked to the NHS net with all the advantages of electronic communication between other service providers in both primary and secondary care.

**PROFESSOR CAMERON SWIFT, PRESIDENT
ELECT, BRITISH GERIATRICS SOCIETY**

Training the specialist physician

long-term care has become the absent element in the training of specialist geriatric physician registrars (SpRs); this is a great paradox considering pioneers of geriatric medicine discovered that by properly addressing needs of individuals in a long-stay setting, significant therapeutic and other benefits could be identified. Now SpRs are disadvantaged by not having access to quality training in this area; they have no realistic regular access to patients in long-term care in the UK. This means there is discontinuity of care and, for future geriatricians, there is a problem of accountability because patients in long-term care are one type of endpoint of the effectiveness and quality of care that has gone before.

There is no evidence base available to us on which to plan our future training. A key function of any academic nursing home to teach specialists must, therefore, have a major emphasis on research and innovation.

SpRs need some training in prevention, the proper deployment of resources in preventing need for long-term care, the procedures and systems for pre-assessing individuals being considered for long-stay care and the procedure for review.

Organisational principles needed to underpin an academic nursing home from an SPR's point of view include:

- 1 a clear operational policy about future residents;
- 2 what would be the levels of dependency at which limits might be set;
- 3 the establishment of some way of collecting data;
- 4 a system for disseminating information and collaborating with locally based training units;
- 5 access to continuing medical education, continuing personal development and exposure to research; and
- 6 linkage to existing academic departments.

Particularly useful experiences a teaching care home might offer SpRs include:

- 1 the issue of the resident as a whole person;
- 2 issues around choice, autonomy, decision-making and the ethical and legislative frameworks;
- 3 interdisciplinary practice in long-stay care and combined coordinated interprofessional teaching programmes;
- 4 systems for quality control and audit; and
- 5 interfaces with primary care and social services.

Specific areas for research needed are:

- 1 the best way of producing a good outcome for individual older people;
- 2 the management of severe disability;
- 3 behavioural problems;
- 4 prevention of falls and fractures;
- 5 optimal use of medication;
- 6 the interdisciplinary management of bowel and bladder dysfunction and continence;
- 7 prevention of pressure sores;
- 8 management of acute illness; and
- 9 management of dying and palliative care.

PROFESSOR ALISTAIR BURNS, DEPARTMENT OF PSYCHIATRY, WITHINGTON HOSPITAL,

Training the psychogeriatrician

Old age psychiatrists are probably now "the barefoot doctors" visiting patients in the community as geriatricians were a decade or two ago. They are called in to nursing homes to see residents with various symptoms or behaviours such as agitation, aggression, depression, confusion, apathy, and wandering. Drug-induced or physical illness are the most common diagnoses. Dementia is a syndrome not a diagnosis;

the underlying disease can be Alzheimer's, vascular or Lewy bodies disease.

When called in, the old age psychiatrist needs above all to take a careful history, 95% of which comes from talking to the care staff, relatives and residents themselves.

Issues of management involve missed diagnoses, sorting out medication, addressing abuse of residents by care staff and resorting to hospital admission for a short stay. Morale amongst care staff, abuse of care staff by residents and mediating between relatives and care staff are other issues the old age psychiatrist may have to deal with.

The training needs of SpRs in old age psychiatry are to:

- 1 be aware of medical problems;
- 2 be aware of guidelines;
- 3 uphold standards of care;
- 4 respect the role of other professionals;
- 5 collaborate with other professional specialties; and
- 6 be aware of design of environments to minimise confusion and facilitate functioning for elderly people.

A recent research project involved 12 homes, six each in an intervention and control group, and 120 residents. Care staff in each home were asked to identify 10 residents over age 80 about whom they had concerns. The intervention was a series of seminars from medical staff plus a weekly visit from the outreach psychiatric nurse. Outcome measures were: the geriatric mental state schedule (GMSS) - a measure of psychiatric problems; the Crichton behaviour-rating scale - a measure of behavioural disturbances; and the Barthel index - a measure of functional capacity and an economic evaluation.

In the control group, the measure of organic features in the 60 residents increased, whereas it stayed the same in the intervention group. Depression stayed the same among controls but decreased in the intervention group. Behaviour and function were unchanged.

More interestingly, the psychological morbidity of the care staff in the intervention group was below that of the control group at six months.

A detailed observational component studying two or three residents in each home, measuring their quality of care and social interactions with staff and other residents, showed a significant change in quality for the better in the intervention group.

A second randomised controlled study looking at the effect of a medication review by a pharmacist in 14 homes with 330 residents over eight months used the same outcome measures as before. The mean number of drugs used by each resident was 5 (range 0-17) and a third were receiving neuroleptic drugs. A total of 261 recommendations were made, 85% of which were to discontinue drugs having no effect and the rest to either start medication or change to an alternative drug. Costs dropped significantly in the intervention group, staff costs in terms of specialist referrals were significantly reduced and deaths were unexpectedly reduced.

In conclusion, there is a need for continued long-term involvement of old age psychiatrists in diagnosing and treating patients in long-term care and for continuity of care. Many interventions identified as beneficial by research could be implemented through existing structures.



The Way Ahead

The concept of the Teaching Care Home seems to be a response to a number of very different agendas - the training of 250,000 workers of different disciplines, the ideal care of people with chronic conditions, and how to develop research and disseminate its findings. Can all these aims be met by a single institution? The answer is probably no; and the concept of linking and sharing ideas through an IT network might indeed be a better solution.

The small scale of most UK nursing homes distinguishes them from the US system with its huge homes and large chains owning them. Therefore, the US models may not be the most appropriate for us to follow.

The categories of people requiring more training include regulators and purchasers, as well as those more directly concerned with care. They are probably unaware of the considerable body of research information already available.

Training *per se* requires further evaluation. We believe training is a good thing but there is little evidence about what difference training makes. We need more research into its effects. Is there any correlation between staff training and the quality of care delivered?

Before campaigning for greater investment in the Teaching Care Home concept, our first priority ought

perhaps to be to try and gather some rather more convincing evidence that investment would make a difference. Creating career paths for care assistants might be a better investment than setting up Teaching Care Homes. Should we be spending more time interviewing staff, rather than patients, to find out what factors influence morale and translate to better quality care. Training may be one of them.

The path forward

It seems to me essential to narrow the concept down, acknowledging there are different agendas and needs that may require us to follow different strategies in order to accommodate them.

For me, the real case for a Teaching Care Home is as a demonstration project designed to further the state of the art. Certainly it would be extraordinarily premature to argue the case for them on the basis of all the agendas aired today. It would be self-defeating to claim too much for them and demand their widespread establishment because money is certainly unlikely to be made available.

Arguing the case for advancing the state of one particular aspect of long-term care such as nurse training might be a better strategy than appearing to claim one instrument will solve all our problems. Sharp focus, advancing on a narrow front, with a demonstration model to see how it works, might be the best bet.



We are in agreement that training in nursing homes is necessary and is currently inadequately provided for. Is the Teaching Care Home concept the way to address that problem? We need to look at the serious reservations put forward today and to consider different options for pilot projects.

I believe the Teaching Care Home and the virtual model are both worthy of further exploration. The next step should perhaps be a workshop to follow up the various options discussed.



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