Assignment 1: Appraising an overall care culture

Example

Word count (excluding titles and tables): 1,645

Part one: Observing and measuring the social psychology within a care service

Prior to undertaking three separate observations using the Quality of Interaction Schedule (QUIS) I informed staff at xxxxxxxx that I was studying for the Person Centred Course and I would at some point carry out observations in the Dementia Suite and xxxxxxxxx. The QUIS observational audit tool is one of a few available, the other most cited tool includes Dementia Care Mapping (DCM), however I used QUIS over DCM as it was the tool I had most experience and understanding of, as a result I had more confidence in my ability to effectively conduct an care behaviour observation audit than using other methods.

I felt that it was essential to inform staff, as being observed by another, particularly one’s manager, can be a very intimidating and undermining experience and potentially create anxiety and stress in the workplace (Brooker at al, 1998). Informing staff would support them as they would hopefully not experience the same level of scrutiny or ‘spying’ if they were uncertain of the purpose of my presence. I continued explain that observations had been demonstrated to improve clinical practice (Jarntvedt et al, 2005) and that being observed can help people better understand who they are and what they are doing (Kitwood, 2007) and therefore improve care for our Residents.

The Dementia Suite consists of xxxxxxxxxx. Residents that live in the Suite have varying degrees of Dementia; between mid to later stages, deemed as Palliative.

I conducted three observations at different 30 minute time periods over one day in the Dementia Suite and Main Building. These included:

- Observation One: 11.30am in the Small Lounge, Dementia Suite
- Observation Two: 12.30pm in the Dining Room, Dementia Suite
- Observation Three 4.00pm in the Large Lounge, Main Building

Methodology of Observations:

To conduct the observation I used the Dementia Care Matters, Care Observation Sheet. I found the sheets effective in enabling me to deconstruct my observations in to five-minute time frames and code any activity or not.
To code the observable behaviour I followed the code guidance sheet so that I could correctly code my observations for later analysis and reflection. Before undertaking my observations I made sure that I understood the criteria for each code so that I would be confident in measuring the behaviour observe correctly and efficiently.

I have found using the QUIS tool a great help in providing quantitative analysis of complex qualitative behaviours, which I have used to inform my plan for changes and improvements and provide staff with information regarding existing care delivery in an accessible format. Nonetheless, the tool is not perfect. Three issues I had were:

- Being unable to scribe all the behaviour I observed in busy environments
- Only taking three 30-minute ‘snap shots’ of care practice which may be unrepresentative of care practice and care culture on the whole (Brooker, 2005)
- Problems identified may require increased resources to solve (Argyle, 2012), and as the homes financial budget is limited, aspirations to improve service may be undermined, and free or very low-cost methods to create and manage positive change can be less effective or have an longer time scale

**Review of Observed Care Culture:**

I used the Key Indicators identified by Brooker (Brooker, 2007) or Personal Detractions by May (cited by Brooker, 2007) to highlight the actions/behaviour observed to contextualised them beyond the 5 codes available on the QUIS for better interpretation by staff and myself.

- Ignoring: Staff entering a room with no interaction or communication with Residents or talking over Residents’
- Physical Environment: Music played to for enjoyment of Residents, however was re-played without inclusion or consultation of Residents’ on choice of music
- Enabling: Staff did not always include Residents’ in choices for their physical care (i.e. food and drink) and assuming preferences
- Objectification: Mention of a carer stating “I will take them to the Dining room”
- Respect: Another carer inviting a Resident to join her for lunch, “Shall we go and have some lunch?”, facilitating the Resident to make a decision for what she desired, although a slightly leading statement
- Infantilisation: Assistance from care staff during lunch time can occur like a child-adult scenario, rather than an equal cooperative partnership
- Communication: Mixed observations of communication ranging from hugely positive to passive, often carer would seem to avoid communication or seam not know what to say
• Inclusion: During the afternoon music activity there was active and positive inclusion of every person in the room
• Warmth: During the music activity there was an atmosphere of warmth and positivity and a real feeling of community

Results: Table 1

<table>
<thead>
<tr>
<th>Period</th>
<th>Time-Frame</th>
<th>Positive Social Interaction</th>
<th>Positive Personal Care</th>
<th>Neutral Care</th>
<th>Negative Protective</th>
<th>Negative Restrictive</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11.30 – 12.00</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>12.30 – 13.30</td>
<td>2</td>
<td>8</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>16.00 – 16.45</td>
<td>16</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTALS</td>
<td>1.75 hours</td>
<td>20</td>
<td>13</td>
<td>16</td>
<td>10</td>
<td>1</td>
</tr>
</tbody>
</table>

Results from the three observations indicate that there is higher proportion of positive care than neutral care at xxxx, however, the majority of the positive care observed occurred during observation three, the afternoon music activity. It can be interpreted that activities like this should be encouraged to promote more positive care. However, it does also skew the overall results, as observations from the first and second period total an overall neutral observation and indicate investigation and measures for improvement.

Part 2: Evaluating methods to improve the quality of life / care culture

After analysing the results the prime areas that I have identified for further investigation and/or action are:

Communication: Interaction between Staff and Residents demonstrated limited empathy or respect for Residents by staff outside of activity times. It also potentially highlighted a lack of Staff understanding of Resident’s life history and therefore methods to facilitate social interaction and enjoyment

Enabling and Individual Preference: On multiple occasions staff did not consult Resident’s on their preference or desire
Ignoring and Limited Social Environment: After identifying many incidents of Staff not acknowledging Residents or creating an active and social environment to promote social interaction between Residents and Staff and Residents which has been demonstrated to be a hugely positive experience for everyone involved

Action Plan:

1) Continuing Staff Training and Development
   i. Ongoing role-playing workshops so carers have a stronger understanding of Resident’s perspective. All carer have received training, however “old culture will easily take over when one’s back is turned” (Sheard, 2007) and why professional development will be on-going
   ii. Ensure that all employees understand Dementia, as it is still often misunderstood even in the caring profession (Brooker, 2007)
   iii. Follow on from training in the class room to identify if changes in ‘real life’ take place through on-going observational audit (measureable impact)
   iv. Train staff in using QUIS so that they can assist in observational audits, and hopefully recognise actions or omissions involving positive, negative or neutral care, so that they can proactively identify and create change.
   v. Equipping staff with the psychological and emotional knowledge and tools to take on their demanding roles, and provide ongoing support through continuing development, supervisions and an open-door policy

2) Promotion of Life Histories
   i. Key Workers asked to learn the life histories of their Key Resident.
   ii. During afternoon handover a Key Worker on duty will share this knowledge with the rest of the team. This will be ongoing so that each carer will have the opportunity to better understand Residents lives.
   iii. On each occasion the hand over team will discuss how the persons experience at xxxxxxx can be improved including suggesting of individual or group activities and topics they could discuss with this person
   iv. This suggesting to be added to the Residents care plan
   v. Better understanding of Residents life history aims to prompt conversation ideas when Carers may be ‘lost for words’ (Sheard, 2007)
   vi. The addition expectation for this is to enable Carer to recognise the Person by acknowledging their life and the value of their life (Brooker, 2007) promoting respect for all fellow humans

3) Creating a Physical Environment that promotes a Social Environment
   i. Placing furniture and items around xxxxxxxxx take make it feel less ‘clinical’ and more ‘homely’
ii. Creating a sense of home in both Residents and Staff (Sheard, 2007) to create an warm environment and a conscious and sob-conscious ethos of ‘our home, our family’ to further breakdown the ‘us and them barrier’ (Kitwood, 2012)

iii. Ensuring that items and materials for activities to occur (i.e. painting, music making, cooking, dancing, reading, movies) are stocked an easily available

iv. Empowering staff to try things out and supporting staff to view activities as everyone’s role (Sheard, 2007); spontaneous social interaction

v. Activities that truly promote and encourage ‘play’, as individual of all ages still require play in their lives (Booth & Jernberg, 2010)

vi. “Play is the glue that bonds us together” (Anderson, 2009); fundamental for bonding relationships, learning to trust and fostering tolerance (Anderson, 2009); “builds authentic relationships” (Brooker, 2007)

vii. Through increase activity and play I hope to breakdown barriers through cooperation and create greater respect, inclusivity, appreciation and happiness for Residents, Families and Staff

4) On-going Recruitment
   i. During recruitment of new staff, internally or externally, during the expansion of the home to use interview techniques that identify attitudes towards loving care (Sheard, 2007), as attitudes are often difficult to change (Kitwood, 2012)

5) Praise and Promotion of Person Centred Care
   i. Identify members of Staff who demonstrate a truly person centred approach to care
   ii. Praise them individually, and on supervision discuss the importance of them as a role model how through their actions and encouragement other members of staff will be empowered to understand and take on a person centred approach. Making role-model ‘Stars’ (Sheard, 2007), to inspire others.
   iii. Value all staff by challenging the cultural perception of ‘Care Workers’ of being low status (Kitwood, 2012). As a manager and senior management team to enable staff to see the difference they make, so that they not only value their role, but know, that as a senior management team, we truly appreciate and value everything they do. By challenging the existing culture, we aim to give the confidence and inspiration for every member of the team to know that they have to power to make dramatic positive impact in theirs and others lives.

**Reflection**
I found conduction the observation audit exceptionally difficult task. My biggest challenge was to remain passive in every scenario when I just wanted to ‘jump in’, however I am glad I remained objective as because of this project I have gain very valuable date to best inform my next tasks as a manager to best avoid future negative interactions at xxxxxxxxxx.

What I have identified is that even though all members of the team in the Dementia Suite have been on many training and workshop events, the message of person centred care is not quite instilled in every member. Although I recognise that all members have the best intentions for every Resident, they unintentionally slip back to ‘old habits’. This is going to be my on-going challenge as a manager, however because of the passion inside me which drives me every day I will keep going until it happens and I can measure the impact.

References