Promoting positive culture in care homes

This briefing sets out the key findings of a research review on 'promoting positive culture in care homes' undertaken by Belinda Dewar, in 2006, as part of the *My* Home Life programme[1]. The briefing also provides examples of promising approaches for improving practice within this area.

The full review providing further tools and examples of 'best practice' can be accessed at the *My* Home Life website (www. myhomelife.org.uk). This review is currently being updated.

Introduction

The culture of a home directly affects the quality of life of residents. A positive culture has the ethos of care built around the resident. It is based on evidence of what makes good care and is continually effective within a changing health and social care context. Effective leadership and management and the availability of expert advice are paramount in creating and maintaining a positive culture.

Relationship-centred care

Studies suggest that we need to change the way we think about older people. The prevalent model in care emphasises the debilitating effects of old age where staff 'do things to' residents. This devalues staff as much as residents. A more positive model is one that emphasises personal growth for residents and staff with a shared commitment to ideas, values, goals and management practices by residents, staff and relatives.

There is a strong focus in this way of working on the importance of relationships, valuing different perspectives and fostering creativity, learning and innovation. It is based on a different level of learning within organisations, one that challenges beliefs, as opposed to imparting facts or rules.

Research suggests that a culture strongly based on relationships leads to positive resident outcomes. For instance, being able to say what you mean without fear or retribution has been linked to lower use of constraints, and increased participation in decision-making by registered nurses has been linked to lowering prevalence of aggressive behaviour among residents. Conversely, specifying work procedures and rules in combination with surveillance has been linked to higher prevalence of complications and immobility.

Common aims

It is increasingly recognised that staff and residents are interdependent and this needs to be considered when fostering positive cultures in care homes. A 'complete community' is consistent with the most positive experiences of older people and 'best care'. In a 'complete community' objectives are enablement and partnership; person-centred and relationship-centred; staff are working as an effective team with mutual appreciation and some blurring of roles; relatives are integral members of the team; interdependence is an important value; and close links are made with the local community.

Several authors advocate that for successful cultural change the important part that each stakeholder plays must be acknowledged.

One report suggests that residents and staff

have six mutual goals. These are to:

*feel safe

*feel physically comfortable

*experience a sense of control

*feel valued as a person

*experience optimal stimulation

*experience pleasure.No pressure/under
  pressure

Supporting the workforce

The availability of trained and well-motivated staff to meet the needs of residents in care homes is an important aspect of the culture (see Briefing No. 7). Team performance will impact on quality of life of residents and resident and staff wellbeing are interdependent.

Research exploring the relationship between staffing and quality of care has typically suggested a linear relationship. For example, as staffing increases, resident outcomes improve, but levels of staffing may not tell the whole story. Training and practice development are key to improvements in the culture of the care home and there is clearly a link with improved quality of life.

Training benefits residents in many ways – it has been shown to reduce the use of sedation and restraint and is likely to generate more individual care and enhanced relationships between staff and residents. Knowledge improves after training, which in turn improves practice and makes a difference to resident care.

Closer working relationships are needed between care homes, the local community and institutions of higher and further education to improve quality of life in care homes, along with greater investment in education and training.

Supportive management

The importance of effective leadership, management and the availability of expert advice to achieve a positive care home community are paramount. However, access to sufficient resources, particularly staff time, is also essential.

Research into job satisfaction and motivation for care home staff stresses the interdependence of staff and residents' wellbeing. It recognises the importance of a management that listens and asks the right questions, and it shows that the development of a learning environment for both staff and residents is necessary to person-centred care and the best possible wellbeing for both. Furthermore, key values, roles, knowledge and skills must not be assumed. A listening, proactive style of management is more likely to encourage open relationships and empower staff to be creative.

Research shows that good managers:

*show an interest in staff and residents;

*are approachable;

*nurture, care, and conciliate and collaborate;

*are unbureaucratic;

*show an interest in people's personal lives;

*offer people their time;

*communicate effectively;

*develop a collegiate culture to promote
  wellbeing in the workplace.

Management strategies that enable successful change to provide a quality service and that help to create a community of practice, include collaboration (pooled knowledge and skills), narration (telling stories about problems and solutions) and improvisation (creative responses to gaps in the real world of practice and the formal rules).

Other support for staff

There is no doubt that care home work is physically and emotionally demanding. Research suggests that approaches to team working need to help staff manage that aspect of their work. Staff need clarity about the goals of care for individual residents and the skills and opportunities to assess whether these goals are achieved. Staff also need to feel that they are appreciated by residents and their families. Having their work recognised and feeling a sense of achievement are important motivators for care assistants. Staff have been found to place high value on simple acts such as being told that their work is valued, as well

as recognition from colleagues, residents and families.

Practice examples

Factors that affect team performance can include job satisfaction, levels of stress and burnout, managerial style and patterns of working. A study about job satisfaction and staff motivation highlighted the importance of emotional health in the workplace and the interdependence of resident and staff wellbeing. Key findings included:

*a listening management, asking the right questions, alongside a learning environment for both staff and residents is necessary to person-centred care and optimal wellbeing for both;

*key values, roles, knowledge and skills must be actively modelled and taught;

*releasing empowerment and creativity within the workplace can overcome the effects of stress and burnout;

*realistic rewards are necessary to reflect task significance of the carer's role.

In a study by Hockley et al. (2005) the quality of end-of-life care was the focus of improvement in eight nursing homes in Scotland using an integrated care pathway (ICP). The project used an action research approach to promote collaboration between staff in nursing homes and the research team, and to empower staff so that they could develop a practice-based theory about end-of-life care that was relevant to them.

The project used the following strategies to promote a culture in the care home that valued changing practice to achieve quality end-of life-care:

*the identification and support of two key champions in each home who would lead the initiative and enhance sustainability of the project once it had finished;

*development of a community of practice that included researchers and practitioners, all of whom wanted to pursue the development of knowledge in relation to end-of-life care;

*the use of action learning sets for key champions in order to challenge espoused theories and theories in use;

*a values clarification exercise to establish the beliefs and values of staff in relation to end-of-life care. The results were formulated into an audit tool that staff could use to determine if they felt their organisation was meeting these goals;

*education sessions on the use of the ICP documentation to key champions and subsequently to all nursing homes;

*collaborative learning groups for all staff following a death in the nursing home; and

*regular clinical support from a clinical nurse specialist (palliative care) and the study team.

Positive outcomes included enhancing the quality of end-of-life care for residents, such as by effective pain control and increased opportunities to talk about death. In addition, practitioners commented on their enhanced self awareness, ability to challenge others, ability to put together a persuasive case for change, enhanced teamwork - particularly with GPs - and opening up the nursing home culture so that talking about death and dying was not feared.

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