



**THE  
VISION**



**FOR A TEACHING/  
RESEARCH-BASED  
CARE HOME**



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This document was developed after scoping the international literature on teaching/research-based care homes; and one-to-one discussions with over 30 professionals within medicine for the care of the older people, old age psychiatry, general practice, community health & social care partnerships, independent care home organisations, Scottish Care, Care Inspectorate and academics from the University of Edinburgh, Queen Margaret University and Edinburgh Napier University. We also visited: The Hogewey Dementia Village in Amsterdam and met Professor Hertogh and colleagues at VU University Medical Centre; visited four teaching nursing homes in Norway and met with Professor Marit Kirkevold; and visited Northgate Care Home, Adelaide, Australia. The concept was further developed during a 'visioning afternoon' held in the Playfair Library, the University of Edinburgh (see Appendix 1). We are very grateful for input from Marilyn Boggust building on her experience at the King's Fund. The interest from throughout Scotland has been very encouraging. The vision is timely and it is hoped that the current feasibility study will show it can be a reality in practice.

For convenience, the teaching/research-based care home vision will be referred to as the Centre.



## **THE VISION SUMMARISED**

To change realities and perceptions of the care of frail older people in care homes through the establishment of a teaching/research-based care home.

The Centre will be developed and sustained through a cohesive multi-partnership model, embracing families, local communities with health and social care professionals, local educational establishments, local care homes, local and central government in the area.

The core objectives of the Centre (care, knowledge and skills development, research and community involvement) will support the ethos of care and compassion.

Innovative design, staffing and management will enable the Centre to become both a showcase for best practice and a rich source for research, skills development and community involvement in the delivery of care to the frail older person.

The outcome of some preliminary research (theoretical and field-based) has shown the need for such an establishment and the potential for its success.

Enthusiastic encouragement and support for the concept were expressed during a facilitated discussion event held in 2015 and attended by representatives of all the key stakeholders.

A Vision Steering Group and a smaller Working Group have been established.

A well-constructed, detailed feasibility study is being carried out, which is exploring all aspects needed to move forward and make the Vision a reality.



**person-centred  
care culture  
underpins the  
vision**

A teal-tinted photograph of a young man and an elderly woman looking at a document together. The young man is on the left, wearing a striped shirt, and the elderly woman is on the right, wearing a dark top. They are both looking down at a document in the center. The background is blurred.

# **OUR VISION: A TEACHING/RESEARCH- BASED CARE HOME**

This document sets out a vision for establishing a teaching/research-based care home in Lothian, Scotland.

The Centre seeks in the next decade to challenge and bring a sea-change to the generally poor perceptions of care homes. It will encourage a new generation of visionary professional carers for frail older people living and dying in care homes across the region. The Centre will be a rich research environment in which to develop and test quality improvements and innovation. Care, skills development and research will be integrated first at local level, then extend to regional and national levels.

The Centre's five core objective areas are:

### **Service provision**

To provide high-quality, compassionate, innovative care for frail older people requiring 24-hour care, including care for people with dementia and those at the end of life, in order to showcase expert holistic care.

### **Knowledge and skills development**

To develop greater knowledge, skills and expertise among staff in care homes, using novel approaches to transform the care home culture. This focus will be extended to health and social care workers supporting frail older people in their own homes.

### **Training of undergraduate/postgraduate students**

To provide a typical setting for multi-disciplinary training in chronic illnesses and multiple co-morbidities. This will be available in collaboration with local universities for students of medicine, nursing, social work and other health professions and would include pharmacists, dieticians, speech & language therapists, dentists, physiotherapists and occupational therapists.

### **Research**

To provide a focus for multi-disciplinary research, practice development and quality improvement programmes, working in partnership with local universities and other sponsors, in collaboration with existing care homes across the region.

### **Community engagement**

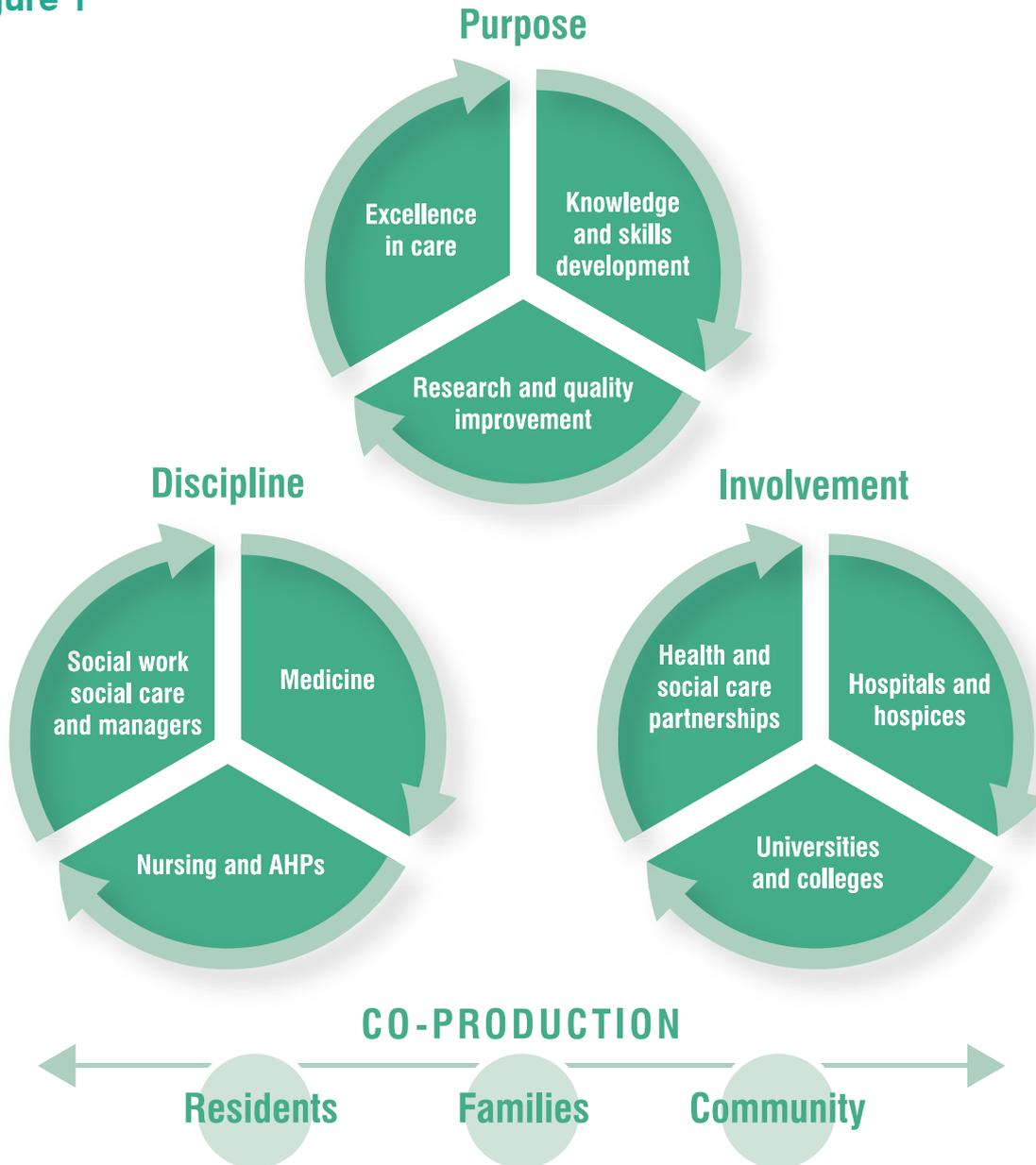
To be part of a local community, engaging with and enabling people to volunteer in care home work; to promote individual and carer resilience and offer support, including innovative respite care, for families caring for frail older people at home.

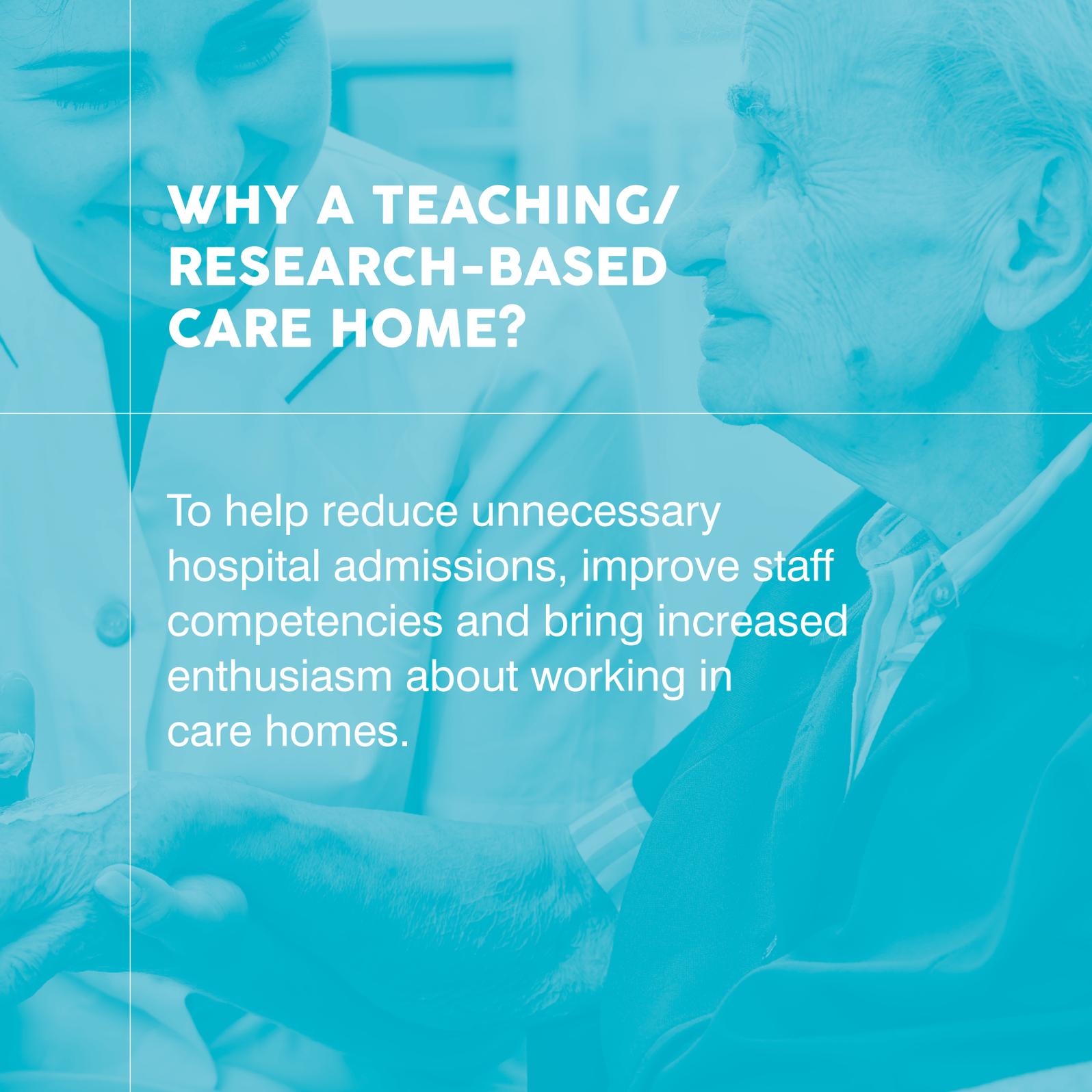
The Centre is based on a cohesive multi-partnership model (Figure 1) embracing: its purpose (excellence in care, knowledge and skills development, and research); its disciplines (nursing, medicine, allied healthcare professionals [AHPs], pharmacists, and social work); and its involvement (hospices, universities, and health & social care partnerships). These are not exclusive and by default will involve care homes across the region, underpinned by a strong resident, family and community focus and involvement.

**student placements  
will also be for:**  
pharmacists  
dietitians, speech  
& language  
therapists, dentists  
physiotherapists  
and occupational  
therapists



**Figure 1**



A young healthcare worker in a white coat is smiling and holding the hand of an elderly man. The image is overlaid with a blue tint. The text is white and positioned in the upper left and center of the image.

## **WHY A TEACHING/ RESEARCH-BASED CARE HOME?**

To help reduce unnecessary hospital admissions, improve staff competencies and bring increased enthusiasm about working in care homes.

Projections of current demographics highlight that, within 10 years, the greatest change in the UK population will be an increase in the number of people over 80 years old. The population in this category, who are likely to require 24-hour care, is projected to increase by 82% by 2030 (Jagger *et al.* 2011). Whether care is given at home or within care homes, there is a need to equip a workforce that is skilled and knowledgeable to care for the frailest in our society.

Teaching/research-based care homes were first developed in the USA in the 1960s as Teaching Nursing Homes (TNHs) in response to scandals about care, and the shortage of trained geriatric healthcare staff (Butler 1981; Mezey & Lynaugh 1989). They became established in the mid-1980s and there was evidence that such facilities not only provided opportunities for teaching, learning and research, but also helped to reduce unnecessary hospital admissions, improve staff competencies and bring increased enthusiasm about working in care homes (Chilvers & Jones 1997). Since then, similar TNHs have been developed in Australia, Norway, The Netherlands and Canada (Barnett 2014; Kirkevold 2008).

Why has this not been tried in the UK? Interestingly, proceedings from a joint British Geriatric Society (BGS) and RSAS AgeCare conference in 1999 (BGS & Royal Society of Aid Surgeons 1999) highlighted the importance of a TNH as a demonstration site. The following year, a 30-bedded TNH was set up by the Guideposts Charitable Trust in Oxford, UK (Upex 2000). It was a TNH for older people with dementia and mental health issues. However, after three years it closed. Among reasons given for its floundering were: the senior nurse behind the vision died within a couple of years of the project commencing; there was little wider collaboration and admissions were restricted to older people with mental health needs with subsequent difficulties filling beds. Lessons learnt from this will be essential for any future UK Centre.



**increased enthusiasm**  
about working in  
care homes



## **CURRENT CARE HOME PROVISION**

Provision of 19,000 care homes,  
with over 478,000 beds across the  
UK – three times the number of all  
acute NHS beds.

In the UK, there has been a rapid increase in the number of independent care home organisations since the 1990s, when Government monies were given to Local Authorities to manage care outwith the NHS. The care of frail older people was transferred to nursing and residential care homes (the majority being independent) through Social Services departments. A strong social rehabilitation model underpinned this development, to counteract the institutionalisation occurring in long-stay geriatric wards which had met people's physical, but not necessarily their holistic, needs. In 2000, further social policy development removed the differentiation between nursing and residential care homes, calling them all 'care homes' and enabling residents to remain where they had been living to the end of their lives. Instead, care homes were differentiated by those with 'on-site nursing' and those simply providing 'personal care'.

The care home business has grown to around 19,000 UK care homes, providing over 478,000 beds (Laing 2015) – three times the number of all acute NHS beds (Illife *et al.* 2016). In Scotland, there are around 900 care homes for frail older people (Laing 2015). Despite these numbers, there continues to be pressure on care packages. Whereas in the 1980s/90s many older people admitted themselves to a care home for care and companionship, current policy aims to support frail older people to stay at home for as long as possible with a variety of care packages. As a result, when admitted to care homes, older people are now very frail with multiple co-morbidities, including dementia (Kinley *et al.* 2014b; Gordon 2015).

Care home staff rely on GPs for medical support who themselves have little specialist training in older people's medicine, unlike in other countries (Briggs *et al.* 2012). The situation is further threatened by the significant undersupply of GPs and district nurses projected by 2020 (Centre for Workforce Intelligence 2014).



**older people in care homes are now very frail with multiple co-morbidities including dementia**

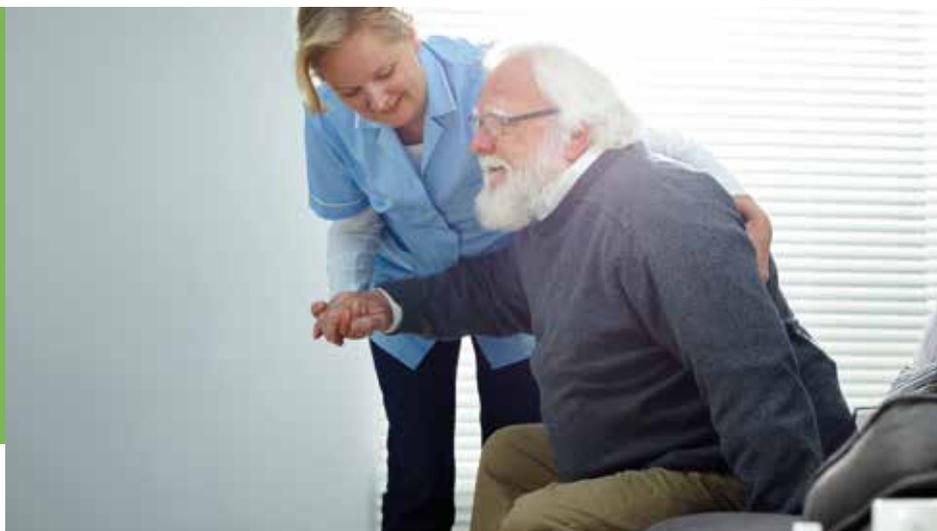
## Care

The BUPA census reported that care homes are no longer an alternative form of housing for frail older people but a location of last resort for individuals with high support needs near the end of life (Lievesley, Crosby & Bowman 2011).

It is now estimated that 80% of people living in care homes have a diagnosis of dementia or serious memory problem as well as other multiple co-morbidities (Alzheimer's Society 2013). The median period from care-home admission to death is 15 months (PSSRU 2011), with 56% of residents dying within a year (Kinley *et al.* 2014).

Most people being cared for in care homes have advanced, progressive diseases – by definition needing 'palliative care' (Lakhani 2015). Palliative care affirms life, aiming to improve the quality of life for those with life-limiting diseases. Around 5.6% UK population die in a hospice, where there is not only a good ratio of nurses and care staff to patients, but also on-site multi-professional teams including social workers, doctors, physiotherapists and pharmacists (Calanzan *et al.* 2013). Interestingly, 19% of the UK population die in a care home (DoH 2012) with few of the resources of hospices.

palliative care  
affirms life





**whilst 79% of care homes provide good care, 21% have been found at 'high risk' of providing poor care**

A YouGov poll of 2000 people found that dementia is feared more than cancer and more than death itself (Alzheimer's Society 2011). While more frail older people die in care homes with nursing on-site, care homes relying on district nurses are increasingly providing end-of-life care.

The UK has many excellent care homes which provide high-quality care for their residents. However, there continues to be a need for improvement. In 2014, 'Re-shaping Care for Older People' highlighted that 21% (193/920) of Scottish care homes were underperforming and at 'high risk' of providing poor care (Scottish Government 2014). A number of issues could contribute, including: lack of good leadership; high staff turnover; recruitment difficulties; greater complexity of care needs for residents with increased co-morbidities; the burden of responsibility on social care workers; lack of on-site nurses and lack of external healthcare support; being poorly resourced by local authorities.

## Knowledge and Skills Development

Many staff enter care home work because they want to help older people but, on entry, few understand the reality of the work. New recruits are given induction training on entry to a care home and will go on to undertake vocational training, but this is rarely at an in-depth health level in spite of the majority of residents having multiple co-morbidities. With little training, low morale and lower pay than NHS counterparts, it is not surprising that there is a high turnover of care home staff (Scottish Care 2015).

Some student nurses are offered clinical placements in care homes with nursing, but not all homes will have enough mentors to make the placement meaningful. For some nurses finding themselves working in care homes, it has not been an active career choice. With the health needs of care home residents becoming more complex, nurses require additional knowledge and skills to manage their patients without hospitalisations. Ensuring the future preparation, recruitment, retention and development of nurses in the sector is of pressing public and policy concern (Spilsbury *et al.* 2015).

Medical students and doctors rarely get any exposure to care homes, let alone practical experience. For social work students, there are limited opportunities in care homes for frail older people. More usually, experience is within children's care homes, learning disability or in mental health as these are most often funded by Social Services. Opportunities for undergraduate, AHPs and student pharmacists to experience care homes are rarely undertaken.

re-shaping  
care for  
older people



## Research

Current research in care homes is minimal compared with other settings. Several UK universities (including Bradford University, Lancaster University, Newcastle University, Queen Margaret University, The University of Edinburgh, University of Hertfordshire, Worcester University) are pioneering research with care homes but they are often one-off projects, with links being broken when staff move on or funding ceases.

Throughout the UK, Enabling Research in Care Homes (ENRICH) is encouraging research-active care homes and could form an important intermediary for the Centre. Many care home managers and owners, once engaged, are delighted to form sustainable links with research and quality improvement initiatives.

An example of this has been a care home project team in SE London established to develop quality palliative and end-of-life care in care homes ([www.stchristophers.org.uk/care-homes](http://www.stchristophers.org.uk/care-homes)). After seven years, the percentage of care home residents dying in hospital was reduced from 54% to 21% across 76 care homes (Hockley & Kinley 2016 – in press). The Centre could have a key role in driving the research agenda in collaboration with residents, their carers and families.



**need for  
solidly  
researched  
evidence**



# **THE WAY AHEAD: THE POTENTIAL ROLE OF THE CENTRE**

The Centre will be underpinned by relationship-based care with a focus on the importance of personhood.

Concern about losing their identity and independence are key to the resistance of many very frail older people to communal 24-hour care. Upholding a person's identity with respect and dignity is fundamental to care and is enshrined in policy. Relationships are significant parts in identity, so time will be taken to strengthen these, whether with friends or family, people from the local community or with Centre staff.

The ethos of care and compassion will be delivered through the key objectives: care, knowledge and skills development, research and community engagement.

## Care

The Centre will provide active, total care in a homely environment. Residents living with and dying from generalised frailty and/or progressive, advanced disease (including dementia, heart failure and stroke) will have care based on the principles of:

- Quality of life – relationships and engagement using ‘life history/biography’ work, person-centred approaches and individually tailored activity;
- Quality of care – good symptom control within an holistic framework of psychosocial and spiritual support;
- Open, friendly communications;
- Care of family and friends;
- Respect, dignity and choice;
- Increasing use of telemedicine.

Care will be organised to promote homeliness, with access to a variety of environments – for example, a sitting room, a shed or ‘workplace’, or a garden. A calm and happy atmosphere would prevail, accepting the need to have honest brave conversations in relation to end-of-life care and cognitive decline, when appropriate.

Staff who enjoy looking after frail older people will be employed. Continuity and consistency will underpin care which, wherever possible, will be ‘for local people by local people’. Staffing, will be based on resident dependency levels, in line with other quality care homes providing nursing care across the Lothians. Management at the Centre, however, will use innovative methods to help augment staffing,

such as volunteers, student placements and restructuring care. An example of the restructuring of care has been demonstrated in the Namaste project (Simard 2014) where people with advanced dementia are brought together for two hours in the morning and two hours in the afternoon for appropriate activity in the stimulation of the five senses. A recent study has shown that quality of life was improved without increase in staffing (Stacpoole *et al.* 2014).

In common with some other care homes, the Centre care team will comprise health and social care workers, nurses and AHPs. Nurses and other AHPs, the foundation of the team, will have a sound knowledge of gerontological evidence-based care and their leadership qualities will empower care workers in the care and assessment of residents.

Monthly multi-disciplinary meetings, will enable the Centre to address the overall holistic needs of residents in the last phase of life. Such meetings will demonstrate excellence in multi-disciplinary anticipatory care, teamwork, open communication, co-operation and support. Initially, medical care will be provided by an attached GP practice and greater involvement of geriatricians will be sought (British Geriatrics Society 2011). Further, the case for care home medicine will be promoted (BMA 2016, Gordon 2015) alongside continuing care of older people in the community. Local attitudes to different models of medical care, including the role of nurse specialists, will be explored.

If there was an opportunity for a new build, then the design and architecture (including the garden/ grounds) would be specific to the needs of people with frailty and dementia. Inside, architecture that promotes an atmosphere of calm, homeliness and of activity with children would be favoured; outside, one that promotes well-being, plants and pets. The potential of technology to contribute to residents' quality of life, to their care and for training purposes will be an important aspect to consider and develop. For example, video-conferencing is being used in care homes to aid consultations and training; iPads for residents to stay connected to family; and, telecare to reduce falls risk and enable safe wandering.

A new build would be preferable as there will be no need for 'cultural change' of an existing facility. Such a facility could also act as a base for innovative teams such as a rapid response community home care/care home team, and an advanced dementia multi-professional team for the region.

## Knowledge and Skills Development

Working with local training institutions and universities, the Centre will be a place of excellence for knowledge and skills development in the care of frail older people with multiple co-morbidities including advanced dementia, heart failure, stroke, Parkinson's disease, general frailty and those requiring end-of-life care. Care home staff will be trained so that they are competent in the care, especially in relation to dementia and palliative care needs, which improves residents' quality of life (Stacpoole *et al.* 2014). Training will increase their confidence in conversations about the end of life and in their support for anticipatory care planning. This will be achieved through regular, ongoing in-house training, including reflective debriefing sessions to support staff following a death.

The Centre will support a radical reconsideration of the nurse's role within care homes, to promote better person-centred care with appropriate outcome measures (McCormack *et al.* 2010; McGilton *et al.* 2012). It will also raise the profile and importance of employing AHPs, for example occupational therapists and physiotherapists, and even pharmacists, as part of core staff groups.

The Centre will be well placed to adapt training to serve the changing healthcare needs of the population and to provide and co-ordinate a rich and widely available learning environment for professionals across the region. It will emphasise the opportunity for shared learning between disciplines, creating a template for collaboration and future multi-disciplinary working.



**opportunities  
for shared  
learning  
between  
disciplines**

The Centre will enhance existing placement offers for nurses, medical students, student pharmacists, AHPs, dental students and junior doctors, with mentoring and tutorials in addition to seeing day-to-day care delivered. Links with local institutions will encourage staff and those from other care homes to undertake formal training, from vocational qualifications (SVQs) to formal postgraduate research qualifications (Masters/PhD).

The Centre could be instrumental in collaborating with training institutions to develop and offer new and relevant qualifications for care workers. Links with existing work, by Professor Brendan McCormack (Queen Margaret University) on a practice development initiative on person-centredness and by Professor Scott Murray (the University of Edinburgh) who organises placements in 50 local GP practices for medical students in their final two years, require to be fostered. Links with the Centre for Research on the Experience of Dementia and the Department of Geriatric Medicine (both the University of Edinburgh), who are keen to explore care home experience for undergraduates, also have potential.

The Centre will actively engage in the training and support of volunteers, both within the Centre and across the region. A Volunteer Organiser post would support this, based on the model and expertise of the hospice movement.

The Centre will not be an isolated ivory tower. Instead, once established, a prime function will be to reach out to care homes and community teams across the region.

rich  
learning  
environment



## Research

The Centre will work with local universities to seek further opportunities to undertake research within care homes across the region. The wide range of disciplines and care homes connected to the Centre will offer the potential for large, well-executed research studies building on current interests such as: person-centred care, stroke, delirium, incontinence and the experience of admission to and discharge from acute hospitals.

The research programme will also complement and inform the Scottish strategic framework for palliative and end-of-life care and include: improving quality of life, dementia care; accelerated hospital discharge; spirituality; family support; use of technology and telemedicine; assessment/management of pain and symptom control; communication in relation to anticipatory care planning.

Research funding will be sought from NIHR, CSO and relevant charities.

Collaboration across other centres in Scotland (for example, the Dementia Services Development Centre and the University of Stirling, the University of the West of Scotland and initiatives supported by the Scottish Government) and elsewhere in the UK (Universities of York and Newcastle) will be important. Existing international links with Norway, the Netherlands and Australia will be strengthened and supported.



**working with local  
and international  
institutions**

A prime role of the Centre, once established, will be to reach out to care homes across the region in a 'hub and spoke' model. Each health and social care partnership (represented by bold green stripes) will have one or more "satellite" care homes (represented by purple stripes) closely associated with the Centre. The satellite care homes will help to lead innovations/training locally. The other thinner stripes represent independent and council care homes.

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**The Centre  
will not be an  
'isolated ivory  
tower'**



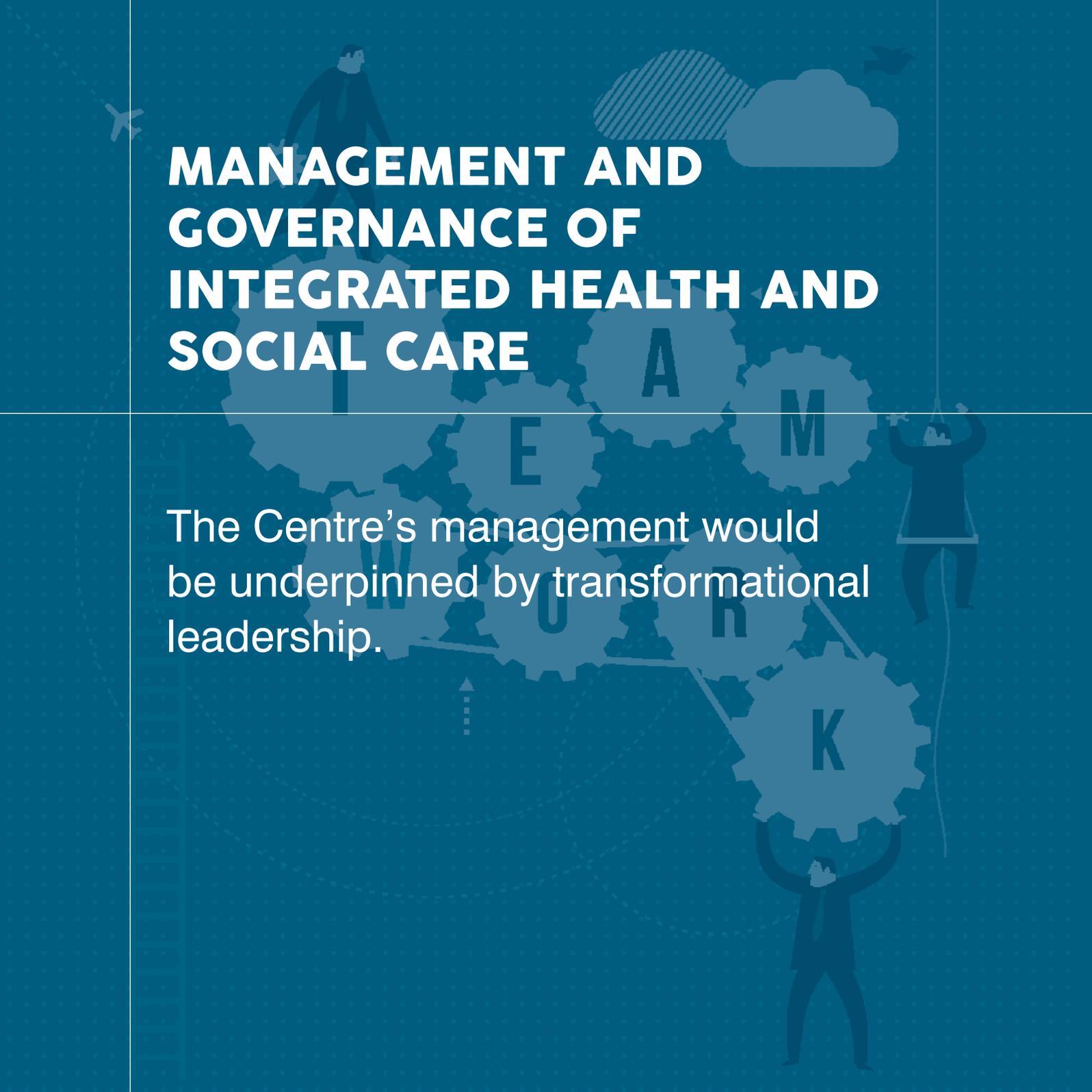
## Community Engagement

A community hub within the Centre will provide a physical space for group activities. These might include music, literary sessions, relaxation, art and faith groups, helped where possible by local volunteers. It will provide a link with the community and act as a resource for frail older people both within and outwith the Centre, and friends and families from within the community. A number of innovative features is envisioned:

1. A café/shop to encourage links with the outside world.
2. A specific area within the hub to provide regular 'day support' for people with dementia. The opening of this beyond 'office hours' will be explored.
3. A programme of training and support for friends and relatives of people with moderate to advanced dementia. A volunteer training programme for care homes across the region.
4. Skilled artists would be offered space in order to work with residents and people from the local community. This would foster exhibitions, performances and cultural events open to the public and residents, and help to dispel isolation and the perception of care homes as 'islands of the old'.

The co-location of nursery or crèche facilities was frequently mentioned during the visioning afternoon (see Appendix 1) and would not only foster a connection between young and old but also provide a facility for the children of staff. The additional inclusion of student accommodation, where part of the rental agreement is for the students to volunteer in the care home, would also be explored (AFP 2014).

The local community will be an important part of the Centre. The availability of a gym and exercise/hydrotherapy pool for specific use by those 75+ years within the community would encourage well-being as well help older people identify with the Centre.

The background is a solid dark blue color. It features several faint, light blue illustrations. At the top, there is a silhouette of a person walking, a striped cloud, and a solid cloud. In the middle, there are several interlocking gears of different sizes. Some of the gears have letters on them: 'T', 'E', 'A', 'M', 'W', 'O', 'R', 'K', and 'K'. At the bottom, there are silhouettes of people: one person is climbing a rope on the right, and another person is holding up a large gear with the letter 'K' on it at the bottom center. There are also some faint lines and shapes scattered throughout the background.

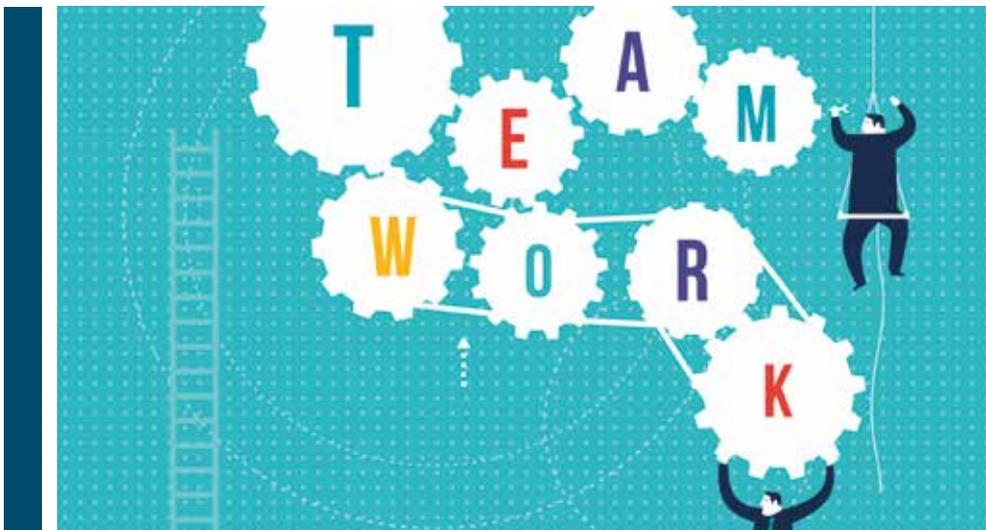
# MANAGEMENT AND GOVERNANCE OF INTEGRATED HEALTH AND SOCIAL CARE

The Centre's management would be underpinned by transformational leadership.

Ideally, the Centre would be managed by one of the Lothian Health & Social Care Partnerships in collaboration with local universities and other academic institutions. Further work during a feasibility study will clarify the possibility of this. Joining with benefactors and/or a not-for-profit care home organisation might also be considered to fill any financial shortfall.

In Scotland, quality of care is overseen by the Care Inspectorate, which is empowered to close care homes with poor standards. The Centre will work in close collaboration with the Care Inspectorate and, with its agreement, might have a role in improving the quality of care in poorly-performing care homes. One model might be to send in a small team (up to six people) to demonstrate high-quality care for several months, aiming to turn around areas of poor practice. At the same time, the poorly-performing care home would appoint the same number/level of staff to work in the Centre. Through these innovative exchanges a more facilitative way of working could be established, without having to close beds and thus put pressure on hospital stays.

The Centre's management will be underpinned by transformational leadership concepts where management creates the conditions for staff to be empowered to learn and motivate each other to higher levels of care. Such leadership sets clear goals, has high expectations, encourages others, provides support and recognition, encourages people to look beyond self-interest and inspires people to reach for the improbable (Bass 1985). This will require a high calibre of staff.



**empowering**  
other care homes

# CONCLUSION

A strategic innovation to improve the care of frail older people in care homes, knowledge and skills development and research.

## Towards Excellence in Care Homes

The vision for a teaching/research-based care home of excellence explored in this document, is an interdisciplinary initiative that bridges health (medical and nursing), social care and allied health care professionals as well as primary and secondary care. It is a long-term vision that will be co-produced with care home residents and their families to bring about sustainable change within care homes across a region. Such a vision is no 'short-term fix'. It proposes a strategic innovation to improve the care of frail older people, knowledge and skills development and research in care homes throughout Lothian over a ten-year period. This should reduce unnecessary admissions to hospitals and promote speedier discharges. Previous work covering Midlothian has demonstrated that a 50% decrease in 'inappropriate' hospital deaths can be achieved (Hockley *et al.* 2010). This and other initiatives will inform practice in the Centre.

A feasibility study is under way which will point the way ahead so that this innovative development could start to be tested in Lothian in 2017/18. The demographics, both of frail older people requiring 24-hour care and those undertaking the care, highlight the urgent need to test this concept.

Hospices have worked to change perceptions of death and dying. This Centre will help to change realities and perceptions of care homes and (particularly) dementia care. The Centre will be responsible for its own residents and will start to support care homes across the region. Once tried in one region, others might follow, so this may have a place in the national strategy that all people in Scotland might live well and, in due course, die well in the community.



**long-term  
vision**

**sustainable  
change**

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## APPENDIX I | A Visioning Afternoon – Playfair Library, The University of Edinburgh



Fifty-six people from a range of professional backgrounds responded to the invitation to attend. They included representatives from medicine, nursing, social work and academia and a range of sectors including the Joint Improvement Team at Scottish Government, the Local Authority, the NHS, the independent care home sector, Universities, Hospices, the Care Inspectorate and Scottish Care.

Professor Scott Murray (Primary Palliative Care Research Group, University of Edinburgh) and Marilyn Boggust (Organisational Development Consultant) introduced the visioning afternoon with a time of encouraging people to highlight why they were interested in attending. Topics that those attending raised included:

- achieving excellence in care homes – what is possible, given that we are all passionate about this?
- sharing good care and communicating it across care homes
- considering the increasing medical needs of residents and yet the scarcity of GP and district nurse support, what new models of care might be possible?
- could working ideas out in more detail be a 'convergent evolution' of health and social care?
- workforce issues including how to educate and support care home staff in an increasingly challenging climate
- making care homes an attractive option for all
- ensuring that care homes are places where students of all disciplines can learn clinical and management skills well.

Hilary Gardner, a clinical nurse specialist, gave an overview of the current care home situation in Edinburgh, which echoed national trends: the increased size of the care home population, and the increased complexity of their needs.

Dr Jo Hockley then described the concept of a teaching/research care home. Acknowledging the good work that is achieved in many care homes, she highlighted that 21% of care homes are nevertheless considered to be 'high risk' and the increasing need for evidence-based care. She outlined the concept of a teaching/research-based care home (TNHs). She described features of TNHs drawing on models which already exist in Norway, Australia, and the Netherlands and the potential of a 'spoke and hub' model whereby the teaching/research care home can influence practice more widely in care homes across a region. Features included: improved retention and recruitment of staff; reduced hospitalisation; important affiliations between care homes and academia; improved quality of care with improved staff competencies; brings a positive attitude to geriatric care, training and research. This stimulated discussion which continued into the break.

In the afternoon, attendees then took part in a world café addressing the question 'what is the ideal?' across a variety of topics ascribed to different tables. The ideas captured at the café were subsequently transcribed and synthesised into themes described overleaf.

It was clear many attendees found describing the 'ideal' a challenge – there were many observations of the current system. Equally, many acknowledged that there are wider elements beyond the scope of the TNH concept which require to be considered since they have an impact on care homes.

Some attendees cited current good practice; these examples have been collated and will be used by the team conducting an in-depth feasibility study once funding has been secured. In addition, there were many sketches of how the hub and spoke model might be configured and other caveats on how the concept could be introduced, for example the pros and cons of the approach to a new build.

## The main themes from the table conversations were:

### *The connection to community*

This was an overarching theme, with the word 'community' appearing more frequently than any other word in the transcripts and mentioned in all topic areas. It appeared in the conversation considering physical aspects of design, where services such as a local café, base for physiotherapists and other professionals, a community sports facility, an art gallery, and, overwhelmingly, the co-location of nursery or crèche facilities, would be included in the physical care home complex.

Links with local schools were cited frequently and considered beneficial on many fronts; promoting reminiscing, providing exchange for young people, supporting the development of positive attitudes to caring and careers in care, developing friendships and providing opportunities for volunteering.

It was clear from responses that the ideal situation would have residents, staff and volunteers drawn from the local community and there would be a connection between the care home and the area on many fronts.

### *Aspects of architecture and design*

Features described were: in the heart of the community; with space for local people to participate in activities; physical amenities which members of the community can share, such as a coffee shop, hairdressers, gym and a place of worship; designed to have links with the outdoors with easy access to and views of a garden. Other features were a dementia-friendly and easily understood design, with wider beds and doors, and use of technology to support this design e.g. Wi-Fi.

Significant requirements were stated as: a physical environment that promotes an atmosphere of calm, homeliness, and of activity with children, plants and pets.

The link between ethos and atmosphere and physical design was noted; how space is allocated sent powerful message of values e.g. sanctuary space, space for activities, dispersed small kitchens and dining areas, space for volunteers and families.

Other aspects noted were:

- There needs to be physical space (one or two rooms) allocated to research and education.
- There can be a tension between optimal design and requirements e.g. infection control and the desire for homeliness.
- The allocation of space for staff can affirm that staff are valued.

### *Ethos and atmosphere*

There was discussion on the model of care and the need for intent in its selection.

Elements of care that contribute to the ethos of such a care home were considered, for example: the ethos of hospitality; an holistic environment; open visiting; having a homely environment and a calm and happy atmosphere; and, the use of music and artefacts such as memory boxes and doll therapy etc to support residents.

Other aspects noted were:

- the contribution of a staff; doing the work they wish to do and doing it well, and giving continuity and consistency of care.
- the significance of choice and independence of the residents; the need for people to flourish and live life with purpose.

Cited in several locations was the need for honesty, bravery or courage in conversations about end-of-life care, death and dying. This relates to staff training requirements.

### *Relationship with residents*

Aspects described were: centred on what patients want and the customer experience; involvement of relatives in care; welcoming for all family; child friendly; good communication with family, relatives, and friends; respectful of residents – collaborative development with residents. This relates to the quality of care that enhances care principles and personalized ongoing care and end-of-life care that empowers people.

### *Staffing the teaching/research based care home*

The wide variety of staff involved in such a care home was noted and the need to have all appropriately trained and aware of dementia and related issues. Adequate staffing levels are important. The ideal was described as: having experienced staff who know the residents and have the right attitude; the significance of motivation, imagination, skills, insight and courage to deal with difficult conversations, for

example around death and dying; staff able to think 'out of the box' to offer care; staff offered opportunities for development and training.

Attendees commenting on this topic made many observations on the wider links to societal attitudes, current training regimes for the related professions, and the need to change the status of care work as a career for all involved.

### *The potential of technology to contribute to residents' quality of life, to care, teaching and research*

The strengths and barriers of use of technology were discussed.

The potential for technology to support the teaching and research function was noted through; links with universities, action learning, teaching outreach, and joint learning case conferences for staff.

Technology also has potential to support residents; to access relatives, have case management reviews, and access help on a variety of well-evidenced areas already demonstrated in Scotland e.g. medicines management, rehabilitation support. Evidence of what works best should be followed, including avoiding complex technology where simpler will be as effective.

### *The connection to research and teaching*

There was awareness of the relative lack of support for training currently in care homes and it was noted that aspects of training need to be developed within the professions and managerial staff.

Acknowledgement that a happy and recognised staff affect residents' health. Particular aspects of training were discussed and acknowledged that this is related to staff morale, recruitment and retention. Observation included: the requirement for good leadership; staff being valued; the involvement of care home staff in education to promote sustainability; and the importance of a career structure for nurses working in care homes. It was noted that the care home would be a research facility. It was observed that in an ideal situation, education and learning is also required for relatives and carers e.g. on issues relating to dementia; caring for people with dementia in their own homes.

### *Finance*

Currently hospices and care homes are funded differently – hospices are funded a third or half of their costs by the government,

the rest is raised through fund-raising; care homes have generally half of their costs met by government if the resident cannot pay towards their care but otherwise residents pay for care. Various suggestions of sources of finance were offered and are in the transcribed notes. There were observations on parallel savings that could be made. Ideas on a consortium model incorporating NHS/ Social care/university. The use of virtual support and technology is related to cost effectiveness.

### *Links to policy, culture and education; the wider context*

There were many observations of the current situation and the need for the current environment to be challenged on a variety of contexts summarised as follows:

- This is a political issue – requiring national debate.
- The 'political will' is required to recognise care homes as a setting to deliver care.
- We need to be honest – this will cost money to do well.
- This is related to staff pay and perception of care as a role. There is a need to make care homes more attractive, through:
  - i. the promotion of work in care homes as a career choice;
  - ii. the introduction of new qualifications (for social carers, for managers, for GPs e.g. a diploma Care Home medicines);
  - iii. including experience of care homes as part of the curriculum in medical and nursing training;
  - iv. expanding opportunities for nursing AHP and medical staff in care homes;
  - v. having an environment that promotes best practice and promotes the status of professions;
  - vi. having appropriate levels of all staff involved, those in the care home and those external e.g. medical staff.

It was noted in concluding remarks that no care home, and no hub and spoke, exists in isolation and that it is important that any such enterprise should seek to connect to centres and programmes promoting similar ambitions, and examples of good work already in evidence.

*Collated at the request of the teaching/research-based project group by Rosemary Hector, Facilitator – July 2015*



