

RAGLAN: A NEW APPROACH TO SUPPORT PEOPLE WITH DEMENTIA IN MONMOUTHSHIRE

INTRODUCTION:

The Raglan Project asks can domiciliary care can be delivered differently. The service supports 14 people living with dementia in a small rural community and replaced the existing homecare service. The ideas arose from discussions with managers and staff. For staff; to be treated with respect, have regular work and know the people they support. For managers; the need to move to relationship based care.

The project moves away from the current model of service delivery to one that doesn't focus on tasks to be performed at specific times by staff in their traditional role of homecarers. Staff are given autonomy to support the choices of the service user. Each member of staff is full-time salaried and employed as part of a team to work flexibly across a service area. Only five staff work in that area and cover for each other. The time spent and activities undertaken are discussed daily with the service user and their family and respond to how they feel. Minimum service levels remain but to deliver flexibility the care plan is a framework for delivery rather than a prescriptive list of tasks.

The project has explored new ways of communicating and recording outcomes. Each member of the team was given an 'iPad' and set up on 'Evernote' to journal their experience and those supported. This has provided extensive case evidence built up over 8 months which continually demonstrates positive outcomes for the people supported.

The principles of the project are as follows:

- Care cannot be provided without establishing a relationship with the person receiving care.
- No uniforms.
- The emotional and social needs of the people supported are as important as their physical needs.
- The needs of the informal carer must not only be assessed but met.
- Decisions are best made by those closest to the issues and we must trust our staff.
- There must be a direct dialogue between the care co-ordinator and the team.

OUTCOME: WE PROMOTE A RELATIONSHIP BASED EXPERIENCE OF RECEIVING CARE - care supports a natural life; promotes choice, control and independence

Homecare traditionally focuses on the physical needs of people to the detriment of other needs. The RP recognises that in supporting people we have to understand their social and emotional needs as well. To support someone to get up, get dressed, means that staff will work with vulnerable people at their most vulnerable. Outside of the RP common practice is that care commences with tasks so in reality staff who do not know the person will commence a relationship by helping them with intimate personal tasks. The RP approach is that we must know the person ordinarily so they spend time establishing a relationship.

M came home from hospital; not eating, drinking, or communicating. She had lost all ability to walk, had short term memory loss and her will to carry on had gone. M was under 5 stone, prone to chest infections and malnourished.

M has a devoted daughter and refused for her 'Ma' to give up. There had been other agencies visiting M so we were just another agency. She had formed an opinion, ready to give battle after what she says was appalling care in hospital.

M's lust for life has returned at 93. We sit and eat with M which the family likes. M enjoys cooked meals, puddings, cuppas, chocolate. M now goes out on Wednesdays, tea dance on Thursdays. M sings along with us, dances with her arms; loves touching, hugging us and communicating. She enjoys her music at home, has visitors enjoys the socials with Friends of Dingestow where she meets old friends and neighbours - connecting with the community.

Something her family never thought would be possible was for her to attend her only Granddaughter's wedding with our support. Her daughter says she has never experienced care like it.

OUTCOME: IMPROVED LISTENING AND ASSESSMENT - we understand 'what matters' to the person.

Mrs SH was becoming forgetful, not paying bills, not eating hot meals, neglecting herself and her home and becoming increasingly isolated. The assessment details her private nature and how she refuses to let people enter the home. At 94 she had been independent up until this point.

The first conversation with Mrs SH was through the letter box to persuade her to let them in. They have worked gently and slowly with this lady to establish a relationship of trust. Mrs SH now sees our team as friends and the team have promoted this relationship because they know that she is reluctant to accept care.

The SW had been worried that Mrs SH didn't have enough money in her house for her daily living expenses. She had been reluctant to spend much on food etc. There had been issues with her bank accounts, she had closed some and could not remember doing so. Consequently she felt uneasy with any talk of her finances. It was not until I parked outside the bank that Mrs SH decided she would withdraw some cash. What a difference it was seeing her do her shopping. She bought lots of nice things to eat, spent ages walking around Waitrose looking at things. Mrs SH looking through the magazines, she has never shown an interest before. She purchased herself a magazine. Tomorrow she is going out for lunch at the Chase with a friend.

I'm taking each day as it comes; moving very slowly as I don't want to upset this lady - I know it has taken a lot for her to let us in.

OUTCOME: SERVICES SUPPORT THE CARER - they will feel involved and listened to. Their health and well-being will be supported.

The RP team really invest time in supporting the carer

The impact of strangers coming to your home cannot be overestimated. Often a difficult time in people's lives, adjusting to changes; loss of freedom, esteem, mobility and changes to relationships.

I felt threatened having people walk around my home. I felt anxious and out of control - I had looked after my wife for the last 13 years and I had been in total control. **(Husband and Carer)**

"...thank you for the Raglan Project. My husband is now able to enjoy the vegetable garden with the help of Roma. Every day he waters and tends his garden"

Consultation with informal carers reveals a catalogue of complaints about not being listened to, care staff changing and repeatedly asking the same questions; but now... One daughter now describes her confidence when going away and how the staff remind her of things to do when she has forgotten. Another carer outlined how nice to be able to say come a little later or earlier.

Intimacy in relationships is not often discussed and having people come into your home can be a barrier. The team have described helping one lady to dress up, put make up and the way her husband saw her for the first time in a long time – saw past the dementia and saw his wife. Other examples have seen staff help overcome moments of stress and bring people closer. The fact that the team acknowledge their relationships is key. One lady explained the importance

"we're now starting to go out on the bus together. I tell them (the team) that if we're not back, don't worry and don't ring the Police – we're just trying to get our lives back"
Wife & Carer

of the simple recognition that they are married and that the team treat them as a couple.

"...you girls make me feel wanted and part of the care team. It gives me strength to carry on; a purpose and I can talk freely about anything that worries me."

OUTCOME – RECONNECTING PEOPLE WITH THEIR LOCAL COMMUNITIES Communities will become more aware of dementia.

During initial discussions with the staff team we discussed our role to support people in the community; to re-establish links and to help people become involved in their local community. What the team have achieved is remarkable.

The team have established two groups; Friends of Raglan and the Friends of Dingestow. Critical is that the team now support people to attend but the people we support are in the minority. The group is independent of social services and sustainable both in terms of the commitment of the local community and financially.

In the journals detailing the work of the team, each is working with the people supported to reconnect. Not just through the socials above but by supporting people to visit friends, go to local shops, buying mobile phones so people can access a local taxi service to get about independently.

OUTCOME: THE ROLE OF OUR STAFF DEVELOPS. Staff feel empowered, valued and their well-being improves.

Poor care is not due to poor terms and conditions as the great work of the majority of homecare demonstrates. Good care is delivered despite this. How valued the team feel and their financial security are crucially linked. The employment status of domiciliary care workers is unique in social care and health. As homecarer employers we are uncertain as to the level of demand. This in itself presents a risk in that we look to avoid a position of over provision. As employers we look to mitigate this risk by passing the liability to our employees. This results in employment practices such as limited guarantees and in some cases 'zero' hour contracts.

Homecare has traditionally operated on command style structures which are re-enforced by processes of allocating work. Authority is not derived from position in the organisation but as a result of knowledge and proximity to the subject of the decision. In the context of the RP the role of management is support; not control. Good outcomes for the people who receive our services are linked to the welfare of the staff. The staff are enthusiastic and motivated. There has



I feel the pressure has been lifted off my head. I don't worry about my wages every month and I'm not worrying when my rota arrives.

I feel excited about my job; my daughter said she has never heard me talking about work so much - just loving it. I put my whole heart into work

been no sickness since September 2012 (initial discussions about the project) to date. In honest interviews the team have described that sickness was a choice previously when faced with low hours of work as they would be paid more.

TWO OF THE TEAM VISIT THE LOCAL COLLEGE TO TALK TO H&SC STUDENTS

What a shock; the students listened to our stories, they was so interested, they looked at our photos of real people, who's life's we have altered, thanks to the way we can work through the project.

Students were crying, taking notes, asking us questions, what an experience we had.....

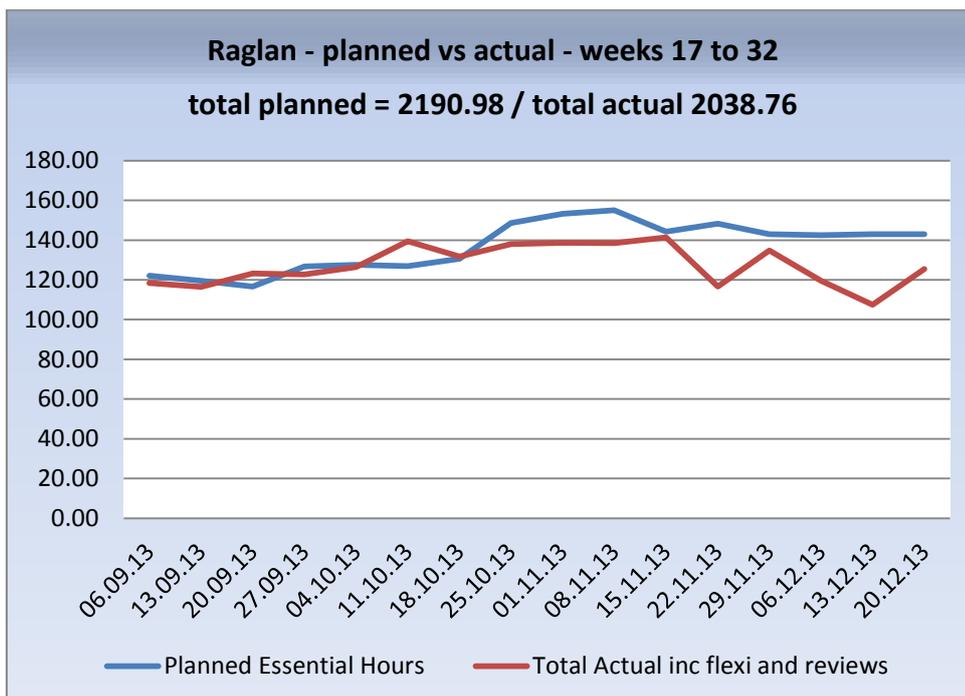
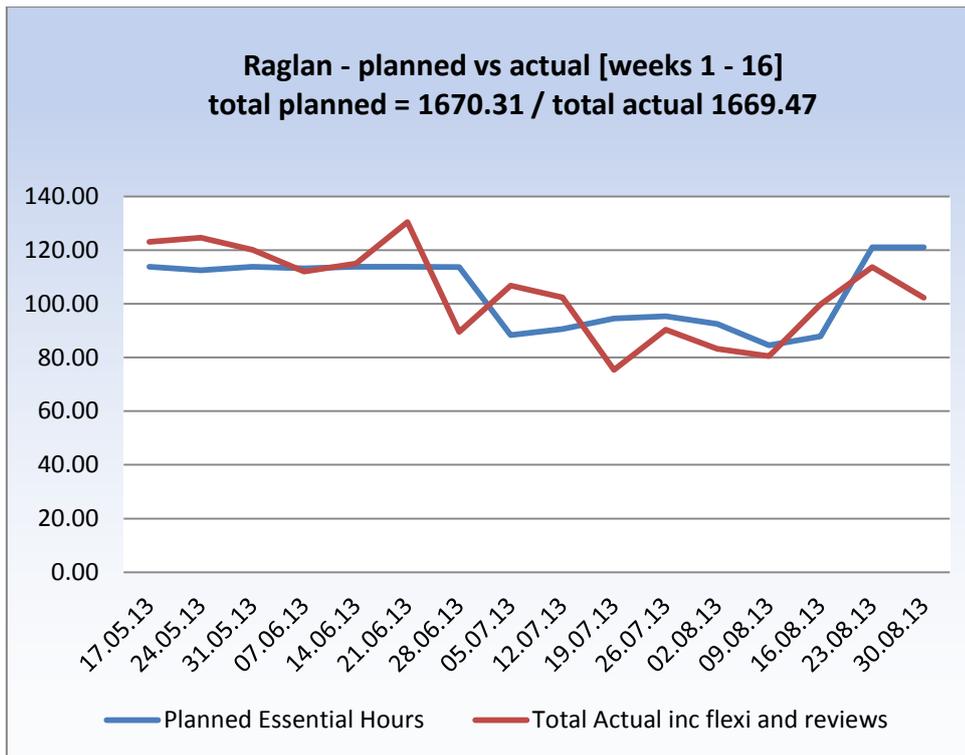
OUTCOMES: THE POTENTIAL TO DELIVER BETTER OUTCOMES AT THE SAME COST IS EXPLORED..

The simple answer; yes it can. Autonomy for staff and direct communication with the care manager has shown costs are actually less. By removing limiting terms and conditions that prevent staff using their own judgement staff will make informed decisions that are mindful of the financial constraints within which they work.

Mr M now feels confident to administer his own medication, we have encouraged and assisted Mr M to cook and he has taken a keen interest again in this task. He is attending tea dances again now that J has attended with him to regain confidence. He now calls on neighbours he feels are vulnerable to encourage them to attend the socials at Dingestow. He now has a purpose and a spring in his step. His care had reduced from 7 hours to just a 1/4 per week.

Care is broken down under different headings in the RP. Daily essentials include help to prepare food, help to dress or wash. Weekly essentials are those things that need supporting each week such as shopping. Flexi is hours allocated to support the person socially. For comparative purposes only daily and weekly essentials have been included in the planned hours.

Because of the autonomy that the staff have, care increases / decreases in response to need. Behind these figures there are people who are being supported at the end of their lives or carers who need additional support as their ability to cope changes. Similarly the planned hours are changing in direct response to the feedback from the staff.



Following consultation with the team and care manager an attempt to predict outcomes without the Raglan Project was attempted. For each person and based on reviews, journaling and interviews we can say that outcomes have improved for everyone supported. If the project did not exist then possibly we can say that three people will have gone into permanent care, one would have died in hospital and for a number of others that they would not have engaged with social services at all.