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Care Homes for Older People with Dementia in the North West of England

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1 EXECUTIVE SUMMARY

1.1 Introduction

This research into long term care services for people with dementia forms part of a larger study undertaken to identify and describe a range of specialist dementia services in the North West of England. 'Specialist' services were defined as: services or resources which are provided exclusively, or which have part of them dedicated specifically, for older people with dementia and/or their informal carers. A broad definition of dementia was adopted, which encapsulated both those formally diagnosed with dementia, and also those who could be described as 'confused'.

The aims of the project were to:

- Identify and describe long-term care homes for people with dementia
- Capture variations in standards
- Capture variation in capacity
- Make the findings available to managers in order to assist service development.

1.2 Methods

Data collection took the form of a postal questionnaire sent to all care homes in the North West of England identified by service managers in health and social services departments as providing some level of care to people with dementia. The response rate was 73 per cent with a total of 287 homes remaining in the sample following the application of rigorous exclusion criteria. Data were analysed using SPSS 10.1. Quality issues were assessed against recent policy and measures developed from other research.

Variations were looked at in relation to:

- Home type
- Local authority

The majority of analyses between home types related to those classified as 'EMI' (elderly mentally infirm) and 'non-EMI' homes with some designated capacity to care for older people with dementia. The term 'elderly mentally infirm' has been in common usage for several decades, introduced as an imprecise catch-all phrase to cover mental illnesses of many kinds among elderly people. Although the term is not a registration category for care homes it is used informally and is understood by home staff. EMI homes are those registered as 'specialist', catering for older people with dementia along side those with other mental disorders. Non-EMI homes were not registered as specialising in the care of older people with mental health problems, although they were registered to care for some people with dementia.

1.3 Key findings: Quality measures in service provision

1.3.1 EMI places

The availability of EMI places in all home types varied greatly across the North West of England. As a whole, the rate per 1000 for the region was between approximately

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7 (recorded) and 9 (estimated) but this mean masked a range of between 1 and 24. Approximately one third of people with dementia are likely to enter residential care. This raises questions about the distribution, scale and mix of care home beds for people with dementia in the region.

1.3.2 Integration

Very few services were integrated according to our range of measures.

1.3.3 Management qualifications

Sixty-two per cent of home managers had a nursing qualification but only a quarter (26 per cent) had a National Vocational Qualification level 4 (or equivalent) in management, a requirement for all managers by 2005. Only 34 homes, 12 per cent of the sample had neither of these qualifications.

1.3.4 Qualified staff

Homes in the North West of England have a staff complement that just meets the minimum set by the Residential forum and National Care Standards Commission (NCSC).

1.3.5 Assessment practices

Seventy-eight per cent of homes stated that they carried out a full assessment of all residents within three months of admission. As a result of these assessments, ninety per cent of these (225) also stated that they produced a care plan. Only a quarter of the sample stated that they held reviews of residents needs on a three monthly or more frequent basis.

Many homes stated that their assessment documents covered some key domains outlined in the research questionnaire. Few specified all of it. The weakest area for the majority of homes was in the social-environmental domain. This covered cultural, recreational and religious aspects of the service users' lives and preferences. Only two per cent of homes covered all five areas of this domain compared with 58 per cent that covered all four of the functional (daily living practices) domain questions, 48 per cent that covered all of the clinical (medical issues) domain questions and 45 per cent that covered all of the cognitive domain questions (mental state).

1.3.6 Rehabilitation/Stimulating activities

Low levels of active engagement in stimulating activities and therapies for people with dementia in residential care were found.

1.3.7 Ethnic minority residents

The number of ethnic minority residents was roughly one third of the figure expected, given the percentage of ethnic minorities over the age of 65 in the population of the North West of England as a whole. Services were found to be culturally insensitive based on the indicators used.

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1.3.8 Targeting/Resident mix

A quarter of the non-EMI homes in this sample (28 per cent) reported that over 60 per cent of their residents were people with dementia. Nursing homes had significantly more residents with dementia than did either residential care homes or dual registered homes.

1.3.9 Independence: Good practice

Homes gave an encouraging response to questions relating to this theme and although there is likely to be an element of social desirability in the responses the results suggest a high level of awareness in homes of the needs of service users in this respect.

1.3.10 Independence: Building design

The majority of homes in the sample had name plaques on people's doors and over three quarters stated that they had a secure outside space. Less than half had uniquely personalised bedroom décor and only seven per cent had carpet zoning. A significant difference was found between EMI and non-EMI homes with EMI homes generally having more of these features.

1.3.11 Privacy

Twelve per cent of all homes had over 20 per cent shared rooms. This standard must be achieved by all new homes by 2007 according to the NCSC. The NCSC also stated that all new builds and extensions must have en-suite facilities. The current sample had a large shortfall in this area with over half the homes (56 per cent) having less than 30 per cent en-suite facilities in rooms. Eighty per cent of all homes had a 'quiet room', something that all homes should have according to the NCSC.

1.3.12 Staff training

The specialist dementia training levels among home staff showed a significant number of staff working with people with dementia who had not received any form of specialist dementia care training (18 per cent). Less than half the care staff in the sample had received a general induction in dementia care (46 per cent), or attended an external dementia care training course (42 per cent). Just over half had attended an informal training course (53 per cent).

1.3.13 Carer support

The results suggest that this is only happening in a limited way. The findings also give some indication of how difficult it can be to provide this type of support effectively. For example 73 per cent of respondents stated that they routinely invited carers to reviews yet only 39 per cent stated that carers routinely attend.

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1.3.14 Respite care

Respite care was offered in the majority of homes (85 per cent) but each home offering this service provided only a small number of places. Overall this meant that the level of respite provision was poor. Designated respite beds represented an even smaller number than those subject to availability: 2 per cent of total places compared with 5 per cent for those subject to availability.

1.4 Key findings: Specialist care versus non-specialist care

The hypothesis that homes that were registered or described themselves as 'EMI' were more likely to offer a 'specialist' and therefore better service to people with dementia than non-EMI homes was not substantively confirmed. However, when compared with non-EMI homes, EMI homes had:

- Significantly more qualified nurse managers in EMI homes compared with
- Significantly more EMI homes with qualified nurses than non-EMI homes, and in particular more Registered Mental Nurses.
- More EMI homes offering regular supervision and appraisals to their qualified nursing staff than did non-EMI homes.
- A greater percentage of Registered Mental Nurses who had attended an external dementia training course.
- Were more likely to have staff employed to run Reality Orientation activities.
- Were more likely to have closed secure gardens, personalised rooms and doors, and signposting features.
- Were more likely to have a Snoezelen room – though only a minority of all homes had such a facility.
- Were more likely to be in touch with their local Alzheimer's Society.

On the other hand significantly more non-EMI homes:

- Routinely invited carers to reviews.
- Had three or more outside professionals visiting the home regularly.
- Offered more respite services than did EMI homes.
- Appeared to place greater emphasis on assessing social and environmental factors in a new resident's life.

Taking these findings together it would suggest that non-EMI homes offered a more social care and community linked model of service than did EMI homes whilst EMI homes appeared to offer a more clinical style of service. However, these differences can be exaggerated by taking them out of the larger context. When these measures are placed among the many others outlined in the results, it can be seen that they represent only a minority of them. In many more cases, differences were statistically insignificant.

1.5 Conclusion

The results demonstrate that care homes are struggling to meet many of the new standards set by the National Care Standards Commission and the National Service Framework (e.g. timing of reviews) though in some areas they appear to be doing well (for example, practices to encourage independence). For many measures targets are less clear and 'good practice' must be a matter of judgement.

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This research has highlighted that in order to improve on current practice and enhance the care home experience for people with dementia there must be more:

- Specialist dementia care training for care staff – both qualified and unqualified
- Management training for managers
- Care staff employed in order to enable staff to engage with residents more frequently and involve them in stimulating activities
- Activity staff employed
- Involvement of key workers with relatives
- Respite provision
- Involvement from community specialists
- Culturally sensitive and person focused practice
- Special building design features

Only by addressing these issues can care homes ensure that the quality of service they offer is compatible with the philosophy of the National Service Framework for Older People and the National Minimum Standards for Care in homes for older people. Public and private sectors will need to work in partnership to enable these developments to take shape as without an increase in funding and the expertise of professional trainers the private home sector will be hard pressed to resolve all of these issues.

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2 INTRODUCTION: UNDERSTANDING QUALITY IN DEMENTIA CARE

This report forms part of a larger study undertaken to identify and describe services providing a significant amount of care to people with dementia in the North West of England. The aims and methods described below relate to residential services only, though they are compatible with the approach used in the larger study as a whole, which also examines day, and home care services as well as those of professional teams.

The aims of the project were twofold. First, to identify, describe and note the location of all specialist care homes involved in the delivery of residential services for people with dementia and their carers within the North West of England. Second, to capture variations in the provision of services, the standard of care, and the capacity of those services, both between services, and between local authority areas within the region. It is hoped that the information obtained in meeting these aims will assist in service development.

Following identification, specialist homes or those offering a degree of service to people with dementia were sent a postal questionnaire. A framework of standards was loosely conceptualised around Donabedian's (1980) evaluation criteria of structure, process and outcome in order to measure the quality of service delivery at a number of different levels. In the context of this study we have adopted Donabedian's definition of structure to describe the physical resources of a care facility, for example, its staff, funding and buildings. Process is defined as the manner in which care is carried out and includes assessment and care planning practices. Outcomes are the results of both structure and process and include concepts such as privacy and person focussed care. All three criteria are not attributes of quality themselves but are "approaches to the acquisition of information about the presence or absence of the attributes that constitute or define quality" (Donabedian, 1980, p90).

The standards of care measured, which form the backbone of the report, have been identified in both the literature and recent policy as being central to the provision of good quality care for older people with dementia. The conceptual framework is summarised in Table 4.1 (methods section) and the executive summary, results section, and discussion and conclusions follow this design. The literature review is grounded in the conceptual model but is articulated according to particular areas of concern addressed by the research. There is, for example, a section on the nature of specialist services for people with dementia. As this is one of the overarching themes of the research, this does not appear as a separate heading in the results section, rather it is integral to it and much of the analysis relates to it. Standards and measures sometimes overlap so that, for example, structural issues of quality are not all found in one place, but linked in with other standards. Building design is an example of this, being a structural concept of quality but also closely linked to the outcomes of choice and independence. As a consequence it is it is sited together with other standards that measure these concepts.

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3 RESIDENTIAL CARE SERVICES FOR OLDER PEOPLE WITH DEMENTIA: A SELECTIVE LITERATURE REVIEW

This chapter provides a selective review of the literature on the nature and quality of residential care homes for older people, focusing particularly on services for people with dementia. Although the work reviewed is predominantly British, where particular studies from overseas have relevance to the picture in the UK these are also discussed. The review is divided into five main sections which reflect the major current debates about the nature of service provision for people with dementia in long-term care: needs and numbers, specialist provision, structural issues of personnel and integration, process issues around individuality, and finally issues relating to the needs of carers and the place of respite care.

In the first section, demographic change is discussed in relation to the growing need for services for people with dementia and the recent policy developments aimed at positively addressing these changes. The second section focuses on the research evidence to date regarding whether specialist services for people with dementia lead to a better care experience. In the third section structural issues including funding, sector, and integrated practice are discussed. This is followed by a review of management and staffing issues in relation to good practice and the need for staff to be appropriately and sufficiently trained in order meet the challenge of working with people with dementia. Section four considers some of the process and content issues of providing person focused care and covers service provision for ethnic minorities, care management practices and quality of life issues relating to both the physical and the care practice environment. Finally, the fifth section considers the needs of carers in relation to residential care and considers the debate about the nature of respite care – a bolster to continued care in the community or not? These themes broadly follow the conceptual framework used in this research. Part of the context for this research is also provided by the National Minimum Standards for Care Homes of Older People (Department of Health, 2001a). These standards, for the first time provide clear tools with which to routinely measure quality of care in homes for older people.

3.1 Needs and numbers

Estimates of the prevalence of dementia and cognitive impairment vary considerably according to the classification system used (Erkinjuntti et al., 1997). Some recent studies put the figure for people with dementia in the United Kingdom at 600,000, representing five per cent of the total population over 65. This figure rises to 20 per cent over the age of 80 (Department of Health, 2001b). Hofman and colleagues, major demographic study (1991), which pooled 23 datasets of European studies, estimated a figure of nine per cent for the population over 65 years of age, over one million people. The present study employed Hofman's estimate (see Table A1 in Appendix 2). It is also important to note that estimates for the United Kingdom suggest that there will be a 50 per cent increase in the total number of persons aged 65 and older with cognitive impairment over the next twenty-five years (Melzer et al., 1997). Furthermore it is estimated that between a quarter and a third of people with dementia, live in residential or nursing homes (Nolan and Grant, 1992; Kavanagh, et al., 1993). The total elderly population living in long-term care homes in the UK in 1999 was approximately 554,100 (Laing and

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Buisson, 1999) comprising 302,200 in residential homes and 213,300 in nursing homes. According to these figures almost 40 per cent of the population of these homes have a cognitive impairment.

A recent study of elderly residents of residential and nursing homes in the North West of England (Mozley et al., 2000) found that 61 per cent of those in residential care were people with dementia whilst the figure was significantly greater for those in nursing homes. Only 10 per cent of this study's cohort was free of cognitive impairment compared with 21 per cent in a similar study between 1994-6 (Mozley et al., 2000). The authors suggest that caution should be used in comparing these figures as different measurement instruments were used in the two studies. Their findings nevertheless, when compared with the findings of earlier studies (Lowther and McLeod, 1974; Masterson et al., 1979; Mann et al., 1984) point to an increase in the proportion of people with dementia entering residential or nursing home care. Interestingly a recent national study found that dementia was the most frequently cited disorder in people admitted to both residential and nursing homes (38 per cent) though it was not necessarily the reason for admission (Netten et al., 2001).

3.1.1 Policy developments

The quality of life for people with dementia in residential and nursing homes has often been questioned, with one recent study showing that people with dementia living in nursing homes or hospital wards were likely to experience only a "fair standard of care" (Ballard et al., 2001). The need for urgent improvement in the standard of care in residential and nursing homes has been emphasised by many, including the present government (Netten, 1993; Marshall, 1997; Department of Health, 2001b). Yet systems of data collection and quality control in individual homes have been inadequate (Ballard et al., 2001; Marshall, 2001; Kerrison and Pollock, 2001), and standardised rating scales for homes or for defining the quality of care on a routine basis were not in place (Kerrison and Pollock, 2001; Innes, 2002). The aim of The National Care Standards Commission, established in April 2002, was to provide greater consistency. Their role has been to monitor and regulate care practices in residential and nursing homes via New Minimum Standards, developed against nationally agreed criteria, in a bid to make the process of regulation more nationally consistent and transparent for service users, relatives, and staff. The 38 standards span a range of care issues including the physical home environment, staff qualifications, assessment and care planning, equity of access, and quality of care issues such as practices to promote independence, choice and dignity of the individual (Department of Health, 2001a). A number of standards have been 'softened' in the third edition of printing (Department of Health, 2003) to reflect the concerns of home owners. They nevertheless require many owners and managers to make major changes to their buildings and practices over the next few years. The new minimum standards signify a recognition of the need for both improved standards and clearer systems of monitoring and measurement.

The National Service Framework for Older People (Department of Health, 2001b) also requires changes to be made in social and health care practices in order that they are able offer an effective and appropriate service to the many different populations of older people living in England today. In particular, long-term care

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facilities are expected to ensure that they provide person-centred care that promotes independence and choice.

3.2 Specialist versus non-specialist services

There has been debate for some years as to whether specialist facilities offer the best model of care for people with dementia or whether integration is more desirable (Chappell and Reid, 2000). The reality is that at the end of the twentieth century, most people with dementia were cared for in mixed settings (Marshall, 1999). The Audit Commission (2000) found that specialist help for people with dementia and their carers was patchy and uncoordinated. A requirement is for more research to assess when segregation is useful and little is still known about the "relative impact of separate versus general policies" in relation to people with dementia (Marshall 1999, p94). Another dimension to this debate is the need to address whether any beneficial practices found in specialist homes could be transferred to non-specialist settings in order to benefit residents with dementia there, as opposed to placing all people with dementia in specialist homes (Netten, 1993).

Despite the limited research findings and the uncertainty of the benefits of specialist provision for people with dementia, both the Audit Commission (2000) and the National Service Framework for Older People (2001b) have recommended that social services departments encourage the development of specialist residential care for this service user group. Evans and colleagues (1981) suggested that in non-specialist accommodation the proportion of elderly people who are confused should not exceed one third. When there is a higher proportion they suggest that the type of regime and the care received by all residents is affected.

Given the progressive nature of dementia, it is likely that some people who develop the condition after admission to residential care or whose condition deteriorates will have to be transferred from one home to another. The potential danger to people with dementia inherent in this situation is recognised (Hallewell et al., 1994; Audit Commission, 2000; Netten, et al., 2002). The Audit Commission noted that one third of residents in specialist nursing homes for older people who have a mental illness had been admitted from other residential or nursing homes "implying that those homes were unable to cope". The report also highlighted the importance of improved support to residential and nursing homes in order to help them to reduce the need for such transfers and recommended the development of single sites for residential and nursing homes which should enable "people to receive more intensive care when they need it without having to experience a change of location or care regime" (Audit Commission, 2000, p.70).

The overall direction of service development appears to be towards all long-term care services becoming 'specialist' in some form, whether via a specialist wing or within the whole facility so that all homes are able to support people with dementia. In the meantime, there is a need for increased support for those who have not yet reached 'specialist' status in order to help them cope with and support residents whose mental state is deteriorating (Audit Commission, 2000).

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3.3 Structural issues

3.3.1 Funding

Over two thirds of all residents of care homes in Great Britain are publicly funded (Netten, et al., 1998; 2001). For older people with mental health problems, the figure is slightly higher, with social service departments funding accounting for 80 per cent of residential home placements and 74 per cent of those in nursing homes (Audit Commission, 2000). There is some confusion as to whether dementia is perceived by government as a health or a social care need. Interestingly, Netten and colleagues have concluded that "privately funded residents with severe cognitive impairment are more likely than publicly funded residents to be found in residential homes" (Netten, et al., 2001, p20). Innes (2002) suggests that the high level of local authority funding of people with dementia in residential and nursing homes is indicative of a shift in how dementia is perceived by government, moving from a health to a social care responsibility.

3.3.2 Sector

Most residential and nursing homes in England are privately owned, reflecting government policies since the 1980's which promoted the growth of private sector long-term residential and nursing home care, with parallel reductions in the provision of publicly provided institutional care facilities (Smith and Ford, 1998). Sixty-nine per cent of nursing and residential homes were in the private sector in 1998 (Laing and Buisson, 1999). There is also a small voluntary, not for profit sector. In legal terms, these are homes that are privately owned but that cannot distribute any profits they might make from their operation. They lie "between the state and the profit making sector" (Ware, 1989, p1). This sector made up 13 per cent of the market in the late 1990's. A minority of these offered a service to older people (Laing and Buisson, 1999).

3.3.3 Integrated provision

The National Service Framework for Older People (Department of Health, 2001b) stated that one of its key aims was to develop an integrated health and social care service for older people including those with dementia. The Audit Commission (2000) also stressed the importance of co-ordination between services and professionals to ensure that the most appropriate care is provided for this group of people. The literature suggests that this is not yet being achieved and that many care homes and hence their residents, find it difficult to access community health services. Recent research has found that in the vast majority of cases, general practitioners were attached to homes rather than service users, reducing individual choice and continuity of care (O'Dea et al., 2000). Specialist nursing services were found, in another recent study, to be accessed by a variable extent depending on the specific specialism. It was reported, for example, that 13 per cent used Stoma Care nurses whilst 83 per cent used continence advisors (Janzon et al., 2000).

Jacobs and Glendinning (2001) examined general practitioner, specialist nursing, and physiotherapy services for residents of residential and nursing homes and found all to be problematic. They cited two recent studies (Nocon and Baldwin,

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1998, Dickinson and Sinclair, 1998) that found that, although rehabilitation services in care homes are known to be key contributors to increasing the quality of the care home experience, there has been a decrease in these services, "with older people being particularly disadvantaged" (Jacobs and Glendinning, 2001, p9). Their own research into access to external services by care homes showed that only five per cent of homes in their sample had direct access to the specialist medical services of a psycho-geriatrician, though those that did so reported good relationships with them. The majority of homes in their survey were however able to access specialist nursing services directly. Access to NHS physiotherapists, occupational therapists and speech and language therapists, on the other hand, was only found in 46 per cent of homes overall whilst equipment and supplies such as incontinence pads, hoists and special mattresses were available from the NHS to only three per cent of homes (Jacobs and Glendinning, 2001; Glendinning et al., 2002).

3.3.4 Managers and staffing

It is only in recent years that caring for people with dementia has been widely regarded as more than providing a clean, warm, and comfortable environment. Despite the work of pioneers such as Tom Kitwood, (1997) many staff and managers are still ignorant of the newer models of dementia care (Marshall, 2001). A review of the literature suggests that there is a dearth of meaningful activities in facilities caring for people with dementia and that the overuse of sedatives for challenging behaviour remains high (Bowie and Mountain, 1993; Armstrong-Esther et al., 1994; Brooker, 1995; Goldsmith, 1996; McGrath and Jackson, 1996; Perrin, 1997). The reason for this lies partly in the under-estimation of the difficulty of caring for people with dementia. This demanding work requires a large investment in terms of training, support and retention of care staff (Marshall, 2001). Yet most staff in residential and nursing homes are untrained and poorly paid, levels of agency staff usage are high, whilst management often fails to provide the constant support and encouragement required. The result is "burnt out staff who have neither the energy nor the drive to provide more than basic physical care" (Marshall, 2001, p410).

3.3.5 Managers

The National Minimum Standards for Care Homes for Older People (Department of Health, 2001a) state that service users should live in a home which is run and managed by a person who is fit to be in charge, of good character and able to discharge his or her responsibilities fully. From 2005, registered managers of care homes must achieve National Vocational Qualification (NVQ) level 4 in management, or equivalent, or a nursing qualification where nursing care is provided. The quality of a residential or nursing home is dependent on a number of factors that interact to affect residents' health and quality of life. It has been suggested that management practices are crucial (Institute of Medicine, 1986). A strong management structure that ensures the implementation of guidelines by front line care staff needs to be in place. A system which enables care staff to observe a direct link between the information they provide on residents and the subsequent care given - by way of involvement been shown to be beneficial to reducing staff turnover rates (Banaszak-Holl and Himes, 1996).

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As Beck and colleagues have asserted:

> “[high] quality [nursing] home care is more likely to occur when the nursing home culture and organisational milieu are part of a shared governance environment where all the partners in nursing homes have a voice and value care nursing assistants’ central role in resident care.” (Beck et al., 1999, p209)

3.3.6 Staff numbers

A low staff to resident ratio has been found to be associated with poor quality care (Newcomer et al., 2001)., 2001; Braithwaite, 2001). The National Care Standards, however, do not recommend a minimum staff/service user ratio but rather state that “the ratios of care staff to service users must be determined according to the assessed needs of residents, and a system operated for calculating staff numbers required, in accordance with guidance recommended by the Department of Health.” (Department of Health, 2001a Standard 27). Minimum standards have been published (Centre for Policy on Ageing, 1996; Wagner Development Group, 1990) but these have no legal status. Current policy guidelines state that homes must either adhere to the formula set out by the Residential Forum (Clough, 2002) or to the criteria previously laid down by the local authority registration unit in which the home is situated. It will be the job of inspectors to calculate the number of staff needed (Department of Health, 2001a) and this process is forecast to be beset with resource intensive complexities and potential for conflict between the care home and inspectors (Kerrison and Pollock, 2001).

3.3.7 Staff training

A number of studies have reported a link between active participation in a training programme and improvement in the well being of residents, as well as higher staff retention rates (Centre for Policy on Ageing, 1996; McMallion et al., 1999). Residents with dementia have special care needs and care staff require specialised knowledge and skills to meet them. Training is given significant priority in the National Service Framework for Older People (Department of Health, 2001b) and the NHS Plan (Cm 4818-I , 2000a). A minimum ratio of 50 per cent trained members of care staff (NVQ level 2 or equivalent) is to be achieved by 2005 (excluding managers or registered nurses, including agency staff) (Standard 28: Department of Health, 2001a). All staff must have induction training within six weeks and foundation training within the first six months of appointment meeting national standards. Furthermore an ongoing training programme must be in place with a minimum of three days training per year, which must equip staff to care for the service user group they work with in the particular service setting (Department of Health, 2001a).

3.3.8 Specific dementia training

Levels of staff knowledge and abilities have been found to be among some of the strongest predictors of stress reduction in dementia care and lower staff turnover has also been associated with more dementia specific training (Grant et al., 1996). In a recent study that examined the dementia training needs of care assistant and nursing assistant staff in continuing care facilities in the North West of England, 66

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per cent of respondents rated training in dementia as a top training priority (Bagley et al., 2003). The study found that there was an enormous demand for training in dementia from both home managers and care staff. From the analysis of staff responses, it appeared that this demand was not addressed by the homes.

3.3.9 Staff supervision

Supervision and support of care staff is also a prerequisite of good dementia care. It is known that working with people with dementia can be both demanding and stressful. An opportunity to talk through concerns and feelings, as well as how to manage particular aspects of a person's care is essential to the staff member's ability to do their job well. It is also an important management tool to ensure that care workers are following correct policies and procedures and performing effectively. According to the Centre for Policy on Ageing staff induction, in-house training, staff meetings and individual supervision should be carefully considered and that the extent to which staff will "need these forms of support will depend on the complexity and stress involved in their work" (Centre for Policy on Ageing, 1996, p4). In relation to staff supervision it is the duty of the registered person to ensure that the home's "induction, training and supervision arrangements are put into practice, (that) care staff receive formal supervision at least six times a year, (that) supervision covers all aspects of practice (and) philosophy of care in the home, (and also) career development needs" (Department of Health, 2001a, Standard 36.1-36.3).

3.3.10 Key workers

Although originally designed to improve the flow of information between field and residential social worker, key worker systems have been endorsed by policy makers since the 1980's as 'good practice' in developing user centred practice in residential care (see Bland, 1997 for a full review). They have also been associated with promoting users' independence (Department of Health, 1989). A joint report by the Residential Care Association and the British Association of Social Workers (1976) identified five main functions for key workers, including drawing up, implementing and updating of care plans, and calling reviews. Bland's study of a number of private, voluntary and public sector homes in the early 1990's found that a 'key person' rather than 'key worker' system tended to be in operation whereby residential care staff were involved in the physical care of residents but were far less likely to be involved in developing care plans or providing recreational opportunities. Bland also noted that the role of key worker predominated in local authority homes, where it had originated in the 1970's (RCA/BASW, 1976).

3.4 Care process and service content issues

3.4.1 Assessment

The National Service Framework for Older People recently defined assessment as "a process whereby the needs of an individual are identified and their impact on daily living and quality of life is evaluated" (Department of Health, 2001b, p151). Effective assessment and management of an older person's care are seen as essential to achieving a good experience and outcome for the service user (Audit

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Commission, 2000; Department of Health, 2001b). It is widely recognised as pivotal to the practice of health and social care in the community, and also important in the determination of eligibility and the decision to enter long-term care (Challis, et al., 1996; Stewart et al., 1999).

The single assessment process is one of the cornerstones of the National Service Framework for Older People (Department of Health, 2001b). Its aim is to offer a service that avoids duplication on the one hand and inappropriate assumptions about an individual's care needs on the other. It stresses the need for different professionals and agencies to work together. The terminology in itself indicates that assessment is not a one off event but a process. For those with complex needs, because of dementia, incontinence or challenging behaviour a fuller assessment might be required (Department of Health, 2001b). Where the need for long-term residential care is a possibility, it is noted that a "full multi-disciplinary assessment should take place to identify opportunities for rehabilitation and to reduce inappropriate admissions" (Department of Health, 2001b, p33). This has been added to by the National Minimum Standards for Care homes for Older People, which states that new service users are admitted only on the basis of a full assessment undertaken by people trained to do so, and to which the prospective resident and relevant professionals have been party (Department of Health, 2001a).

There is thus an expectation that care homes will be part of an assessment process. Standard Three of the NCSC Minimum Standards states that where a person has been assessed by a care manager, the home must obtain a copy of both this assessment and the care plan resulting from it. For self-funded individuals and all those without a care management assessment/care plan, the home must carry out its own comprehensive needs assessment (Department of Health, 2001a).

3.4.2 Care plans

The linkage between assessment, care planning and periodic review is seen as vital to good practice (Challis, et al., 1998; Stewart et al., 1999). Both the National Service Framework for Older People (Department of Health 2001a, standard 2) and the National Minimum Standards (Department of Health 2001b, standard 7) state that a comprehensive care plan must be part of the assessment process for all older people, including those with mental health problems. The latter states that a service user plan of care should be generated from a comprehensive assessment for each service user. This provides the basis of the care to be delivered. The care plan is intricately linked to the original assessment and cannot be considered adequate if the initial assessment is incomplete. In an environment which provides care to the older person with dementia, care plans which carry information on the individual's personal preferences and lifestyle, are of great importance as the service user may not always be able to express his or her own wishes (Wallum, 1995).

The care plan was seen as a valuable building block in the National Health Service and Community Care Act 1990 but one deficiency of the implementation of the Act has been seen as the failure to implement a standardised, routine data set for the

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monitoring of care plans (Kerrison and Pollock, 2001). The new framework requires that a care plan is completed for each service user but there are no arrangements for collecting standardised information on the care plans. For the process to work, it is also important that staff are effectively trained and skilled in documenting care plans (Webb and Pontin, 1997; Mueller et al., 2001).

3.4.3 Reviews

Evidence suggests that social service departments have not always prioritised reviews of service users needs in the community due to pressure of other care management practices (Department of Health, 1993; 1998c). Nor was there policy or guidance until recently indicating either the timing or nature of the review process. In relation to reviews for people with dementia in residential and nursing home care there has also been little research regarding the optimal timing of these. One agency suggested it should be four monthly in their guidelines to practice (Alzheimer's Society of Canada, 1992). In 1998 under the banner of Fair Access to Care Services (Department of Health, 1998b, Cm 4169) clearer guidance was given on the timing and nature of reviews for older people in the community. From April 2003, care packages have had to be reviewed "within three months of help first being provided or major changes made to current services" and thereafter at least annually (Department of Health, 1998b, Cm 4169). They must also involve service users, carers and other professionals, and be face-to-face meetings in all but exceptional circumstances. The National Minimum Standards for care homes for older people bring this guidance into line for those in long-term care facilities. They state that care plans must be reviewed by staff in the home on a monthly basis and "updated to reflect the changing needs" (Department of Health, 2001a, Standard 7).

3.4.4 Meaningful activities and the concept of rehabilitation

Despite the development of intermediate care (Department of Health, 2000a; 2001b) active rehabilitation is unlikely to be part of the care plan of the majority of residents in nursing and residential care homes. However, the concept and the practices that result from it are nevertheless helpful for this group of people (Bach, et al., 1995). Active engagement and involvement in a range of activities and interactions have been highlighted as a crucial element in the well being of people with dementia (Finch and Orrell, 1999). The National Minimum Standards indicate that individuals in later life continue to be individuals, with a range of social, cultural, recreational and occupational characteristics. Standard 12 states that the opportunities for stimulation - through leisure and recreation activities - in and outside the home should be flexible and varied to suit service users' "expectations, preferences and capacities", giving particular consideration to people with dementia (Department of Health, 2001a, paragraph 12.1). They highlight the importance of service users having choice and control over these matters. However, measuring these factors can be difficult when addressing the needs of those with a degenerating condition (Perin, 1997). A number of studies, nevertheless, attempt to do this and demonstrate the input that particular types of activities can make (Martichuski et al., 1996; Logsdon and Teri, 1997). A small qualitative study of the social environment of people with dementia in a long-stay care facility found that stimulation and meaningful activity were vital components of both wellbeing and functional ability amongst residents (Morgan and Stewart, 1997). Both professional

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carers and relatives' thought that stimulating activities raised resident's sense of self worth, reduced boredom and agitation, and induced both relaxation and alertness.

A recent randomised controlled trial of reality orientation techniques (Spector et al., 2000) concluded that reality orientation has benefits for both cognition and behaviour for people with dementia. However for these benefits to be sustained, reality orientation programmes may need to be ongoing. Memory training has also shown promise in improving both cognition and behaviour (Floyd and Scogin, 1997; Spector et al., 2002). There is however insufficient evidence to support the use of validation therapy, reminiscence therapy, music therapy (Contributors to the Cochrane Collaboration and the Campbell Collaboration, 2000).

The Centre for Policy on Ageing (1996) has stated that all homes should provide stimulating activities for their residents. The new standards for residential and nursing homes for older people describe interaction and daily activity as one of eleven key domains. Despite this, previous research has shown a very low level of activity programmes to be present which are specific to residents with dementia (Netten, 1993; Teresi et al., 1998; Younger et al., 2000; Ballard et al., 2001). In a recent cross sectional survey which assessed the quality of care in private sector and NHS facilities for people with dementia, Ballard et al., (2001) found that over the six hour daytime period of observation, people spent only fifty minutes (14 per cent) talking or communicating in other ways with staff or other residents, and eleven minutes (3 per cent) engaged in everyday constructive activities other than watching television. Sixty-one minutes (17 per cent) were spent asleep and one hundred and eight minutes (30 per cent) either socially withdrawn or not actively engaged in any form of basic or constructive activity. The remaining 33 per cent of the observation period was spent engaged in basic activities such as eating and going to the toilet (Ballard et al., 2001). The authors concluded that no home showed even a fair standard of care. Although successful and innovative programmes appear to be rare, examples can be found, such as one which brought together older adults with dementia and pre-school children (Camp et al., 1997). The study indicated that adults with dementia could serve as effective mentors and teachers to children in a structured setting.

3.4.5 Equity of access and the needs of minority ethnic groups

One of the key principles set out in the NHS Plan (Department of Health, 2000a) is that services must be shaped and resourced appropriately so that they can respond effectively to the needs of different populations. The National Service Framework for Older People (Department of Health, 2001b) recognises that older people from ethnic minorities can be particularly disadvantaged and are likely to suffer more difficulty in accessing services than are the general population (Department of Health, 1998a; Patel and Mirza, 1998). The Department of Health has also noted that the specific needs of people from diverse cultural groups are often not properly addressed in the assessment process (Department of Health, 1998).

It is estimated that the total black and minority ethnic population of Great Britain is just over three million (5.5 per cent of the total population) (Owen, 1996). Of these 97,100 were over the age of 65 years in 1991, just 4.2 per cent of this population

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(Patel and Mirza, 1998). Using Hoffman and colleagues calculations (See Appendix 2) this would mean that in 1991 there were approximately 9,000 people over the age of sixty-five years from ethnic minority groups with dementia in the UK. Although a small group, it is a growing one and as such its members with dementia are also increasing. Information on the prevalence of Alzheimer's disease in ethnic minorities is limited, but research suggests that it is a 'hidden' rather than a 'non-existent' problem (Brownlie, 1991).

In relation to services for people with dementia it has been noted as late as 1998 that the "world of dementia is colour blind and minority communities are dementia blind (Patel and Mirza, 1998, p5). This accusation is based on evidence which uncovers the difficulties of diagnosis based on clashes of culture between professionals and families, and the difficulties in accessing services based on language differences, lack of information, and the complexity of the care system. The structural disadvantages faced by ethnic minority groups in accessing services are made all the harder by the stigma attached to dementia within many of them. For example, a recent study of three minority ethnic groups in Bradford noted that:

> "we have come to learn that the nearest equivalent term for dementia commonly recognised across a range of South Asian languages happens to be one of the most serious insults that could be levelled against anyone within these ethnic groups" (Mackenzie and Gallagher, 2002, p86).

Patel and Mirza (1998) also observed that stigma was widespread and concluded that professionals need to get closer to these groups to provide information about dementia in order to reduce the associated stigma. Currently carers in these communities tend to struggle to care alone whilst the person with dementia does not come to the attention of service providers until later in the illness.

3.4.6 Good practice and the physical environment

The promotion of independence is one of the core values of good quality care in residential homes for older people (Department of Health, 1989). The National Minimum Standards state that homes should maximise service user's capacity to exercise personal autonomy and choice (Department of Health, 2001a;). Two aspects of this, building design and the management of privacy, are discussed below.

Building design features

Buildings have the capacity to reduce stress, assist functioning and prevent behavioural difficulties (Marshall and Cox, 1998). Most buildings, however, are based on the *disease* model of dementia which focuses on the inevitability of decline and are designed with comfort and safety at their centre (Marshall and Cox, 1998). If dementia is viewed as a *disability*, however, (characterised by impairments in memory, reasoning, and ability to learn, with high levels of stress and an acute sensitivity to the social and built environment) design features could aim to make a positive impact on these characteristics (Marshall and Cox, 1998).

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The National Care Standards promote this approach stating that:

> "People with dementia have particular needs for the layout of communal space and associated signage which aids their remaining capacity" (Department of Health, 2001a, p23).

It is particularly important that residents with cognitive impairment are helped to remain independent and find their way about by visual access, so they see or sense where they are or where they want to go (Calkins, 1988). Orientation difficulties resulting from the condition mean that people with dementia will be particularly dependent on external cues. In a stratified random sample of 46 care homes in Leeds (Tune and Bowie, 2000), the environmental quality of residential and nursing care for people in terms of care practices, social activities, social facilities, reality orientation cues, physical condition and space availability was assessed. The authors concluded that the environmental quality of community-based residential care was generally good, but improvements could be made, particularly with reality orientation cues. They found that no aspect of environmental quality was superior in the specialist EMI homes compared with others, though they acknowledge that this may have been due to factors not captured by the study. They noted that there are a number of fairly basic design features that could relatively easily be improved (carpet zoning, night lights, name plaques on resident's rooms, signposting) whose provision might be associated with improvement in resident behaviour (Tune and Bowie, 2000). A number of useful texts now exist for care home providers who want advice about what is involved in designing, setting up and maintaining a good dementia care home, for example, Cantley and Wilson (2002). The environment should also promote individuality. Around half of the sample in Cantley and Wilson's study practiced some relatively simple methods including personalising bedroom doors, which can also act as a cue to visual access, and bedroom décor. These practices are also beneficial for individual's need for personal territory (Netten et al., 1989).

Privacy

Care home standards state that arrangements for health and personal care should ensure that service users' privacy and dignity are respected at all times (Department of Health, 2001a). The erosion of privacy in the name of protection is a particular experience for people with dementia. Netten notes that it is consequently important to identify how much an individual is "able to experience privacy" and tailor the environment accordingly (Netten, 1993, p33). Care home standards, first set out in a consultation document, *Fit for the Future* (Department of Health, 1990), stated that by April 2002 no care home should have more than 25 per cent of its rooms shared. In response, care home owners successfully lobbied ministers to delay the change, arguing that the already parlous financial state of many homes would be made worse if this change was pushed through too quickly. Standard 23 now states that all new builds, extensions and first time registrations must have 100 per cent single rooms. Existing homes however can continue to provide accommodation in shared rooms at the same level of provision as at the end of August 2002 (Department of Health, 2003). Standard 21 states that all new builds, extensions and first time registrations must have en-suite facilities in all rooms from April 2002, whilst Standard 20 indicates that all homes must have

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available rooms other than bedrooms where service users can meet visitors in private (Department of Health, 2003).

3.5 Service quality issues

3.5.1 Carer involvement

Many carers of older people with dementia are themselves quite old and almost 60 per cent are husbands or wives (Levin et al., 1994). It is clear that services can make a large impact on the ability of carers to continue caring (Levin, 1997). A recent study has shown significant levels of depression and anxiety in spouse carers whose spouse has moved into long term care (Bunting and Charlesworth, 2001). One of the most important predictors of depression was the lack of a clear social support network. Another study of carers of people with dementia, whose relatives had been admitted to long term care homes, found that stress and anxiety were caused by the feeling of being left out of decisions made about their relatives (Almberg et al., 2000). A higher degree of integration in a social network is likely to have a positive effect on wellbeing (Cohen et al., 1985). Keeping the family informed is widely recognised as an important source of support. Bunting and Charlesworth (2001) recommend the implementation of strategies that enhance the availability of social support. There are a number of techniques for achieving greater autonomy for relatives and Marshall (1999) notes that the Scottish Dementia Services Development Centre has produced a practice guide to assist staff in involving relatives.

3.5.2 Respite provision

One of the key policy principles relating to people with dementia espoused by all European countries (Marshall, 1999) is that people with dementia should be enabled to remain at home for as long as possible (Sutherland, 1999). Services that support individual carers and offer services, such as day care and overnight respite care to people with dementia, are important to the realisation of this principle. The primary aims of respite care services are to reduce the stress on carers by giving them a break, which in turn might enable them to continue to provide care for longer, to prevent functional impairment in older people, and to prevent inappropriate placement in hospital or care homes.

The concept of prevention in relation to respite care is not straightforward. There may be positive beneficial effects for the carers when used in combination with day care (Allen, 1983; Levin et al., 1989). However, reviews and meta-analyses of interventions to provide help to carers, including respite care, have generally concluded that the results of these interventions have little impact on 'carer distress' (Knight et al., 1983; Homer and Gilleard, 1994; Thompson and Thompson, 1999). There are, however, usually caveats to such conclusions: studies are often small, of low methodological quality and interventions are often heterogeneous, making the interpretation of the results difficult.

Levin and colleagues (1994) provide a contradictory picture of research to date into respite services for people with dementia. They suggest that some of this variation can be explained by methodological inconsistencies. Some (Pearson et al., 1988)

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hold the view that respite services can delay permanent placement in residential care whilst others have found that, by giving carers a taste for this type of care, overnight respite services might even facilitate the caregiver to break their emotional bonds, overcome their apprehension about residential or nursing care and actually speed up the process of permanent placement (Levin et al., 1989, Zarit et al., 1999). As a result of the limitations of the research evidence, Thompson and Thompson (1999) conclude that it is possible neither to recommend a wholesale investment in this type of carer support nor the withdrawal of the same. Despite these inconclusive results and the varied benefits there is a commonly held view that respite care is a good thing. The Audit Commission (2000) stated that "Social Services should reserve and pay for a number of places for respite care in residential or nursing homes on a continuous basis" (paragraph 117).

3.6 Conclusion

This review has highlighted some of the major themes around the provision of long-term care for older people with dementia: the growing numbers, the move to specialist provision, the importance of integration, the needs of carers, as well as current policy and research views on good practice. The latter stresses the need to recognise people with dementia as individuals and to ensure that care facilities offer appropriate types of service to ensure that maximum choice, privacy, and dignity are maintained. These themes will be addressed further in the findings of this research into long-term care services for people with dementia in the North West of England.

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4 METHODS

The current study, which forms part of a larger research project mapping the nature of all services for people with dementia in the North West of England, was designed to identify residential services that had a specialist focus on dementia care. These were defined as: services or resources which are provided exclusively, or which have part of them dedicated specifically, for older people with dementia and/or their informal carers (Audit Commission, 2000). A broad definition of dementia was adopted, which encapsulated both those formally diagnosed with dementia, and also those who could be described as 'confused'. It was not essential that service users had a diagnosis of dementia; what was important was 'the presenting pattern of need' (Spicker and Gordon, 1997, p49). There were two phases to the data collection.

4.1 Phase one: Data collection - identification of services

Specialist dementia residential services were initially identified from the Laing and Buisson Care Home and Hospital Information CD-Rom (2000). This information was supplemented by means of a screening questionnaire sent to key personnel in the NHS trusts, health authorities, social services departments and voluntary organisations in the North West of England. Respondents were asked to identify existing residential services on a short postal questionnaire. Information was also requested on: service users; whether or not the services were currently in existence or were at the planning stage (with secured funding); a brief service description and contact details.

The services identified in these processes were entered onto a Microsoft Access database and checked for duplicate entries. The accuracy of the results was also checked by local health and social care professionals including those attending three local conferences on dementia care (around 200 local delegates*)*. Adjustments to the database were made as required.

4.2 Phase two: Data collection - description of specialist dementia services

Service configuration, resources and patterns of service were ascertained by means of a postal questionnaire survey. This was developed through reviewing the relevant literature, in particular evidence about the most recent standards of care and quality (see below). Questions were related to indicators of good practice on a range of themes designed to capture the construct of the 'new culture of dementia care' (Kitwood and Benson, 1997), and data was collected within a conceptual framework to reflect the health service evaluation criteria of Donabedian (1980), namely, structure, process and outcome. 'Structure' refers to the resources used in the provision of care, 'process' refers to the activities that constitute care, and 'outcomes' are the consequences of the care provided (Donabedian, 1980). Outcomes may be considered broadly as of two types. "Intermediate outcomes" are "part way accomplishments on the road to desired outcomes" (Weiss, 1998, p129). "Final outcomes" represent the effect of care upon an individual, an effect valued in its own right, such as an improvement in well-being (Challis, 1981; Davies and Knapp, 1981). In the present study the outcomes were necessarily intermediate markers of progress, reflecting the patterns of service output, for example the number of places per service. Respondents were also asked for information relating to the

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organisational context: service type; availability; access; capacity; utilisation and whether or not they were aware of any gaps in local services for people with dementia. At the end of the questionnaire, they were invited to assess their level of confidence in the information provided as a check on the reliability of the data.

Data collection took place between 2000 and 2001. Each of the specialist dementia services identified in the initial phase were sent the questionnaire (see Appendix 1). A researcher contacted non-respondents by telephone; and an additional questionnaire was sent if required. This method proved particularly effective at increasing the response rate.

4.3 Analysis and categorisation of specialist dementia services

To increase the specificity of the data, further selection criteria were imposed, following data collection (see Figure 4.1). Homes with less than twenty per cent of residents with dementia were excluded unless they:

- Defined their home as a specialist EMI residential home, specialist EMI nursing home or dual registered EMI home or
- Had any specifically designated places for people with dementia or
- Specified that they cared for people with dementia in their publicity material.

It should be noted that the categories outlined above were changed by the National Care Standards Commission in 2002 as a result of the Registered Homes Act 2002. Homes are currently registered as either care homes or care homes with nursing with a number of sub-categories attached to these including caring for a specific number of people with dementia. However, this report has used the terminology of the categories in use at the time of data collection.

To ensure the data analysed were of good quality, returns that were deemed unreliable were excluded. These were:

- Respondents who only felt confident answering a few of the questions;
- Respondents with missing data on four questions central to the identification of the resource as providing specialist care for older people with dementia (questions: 1, 5, 8, or 9).

Two hundred and eighty-seven homes were included in the sample. The data collection process is detailed in the flowchart in Figure 4.1.

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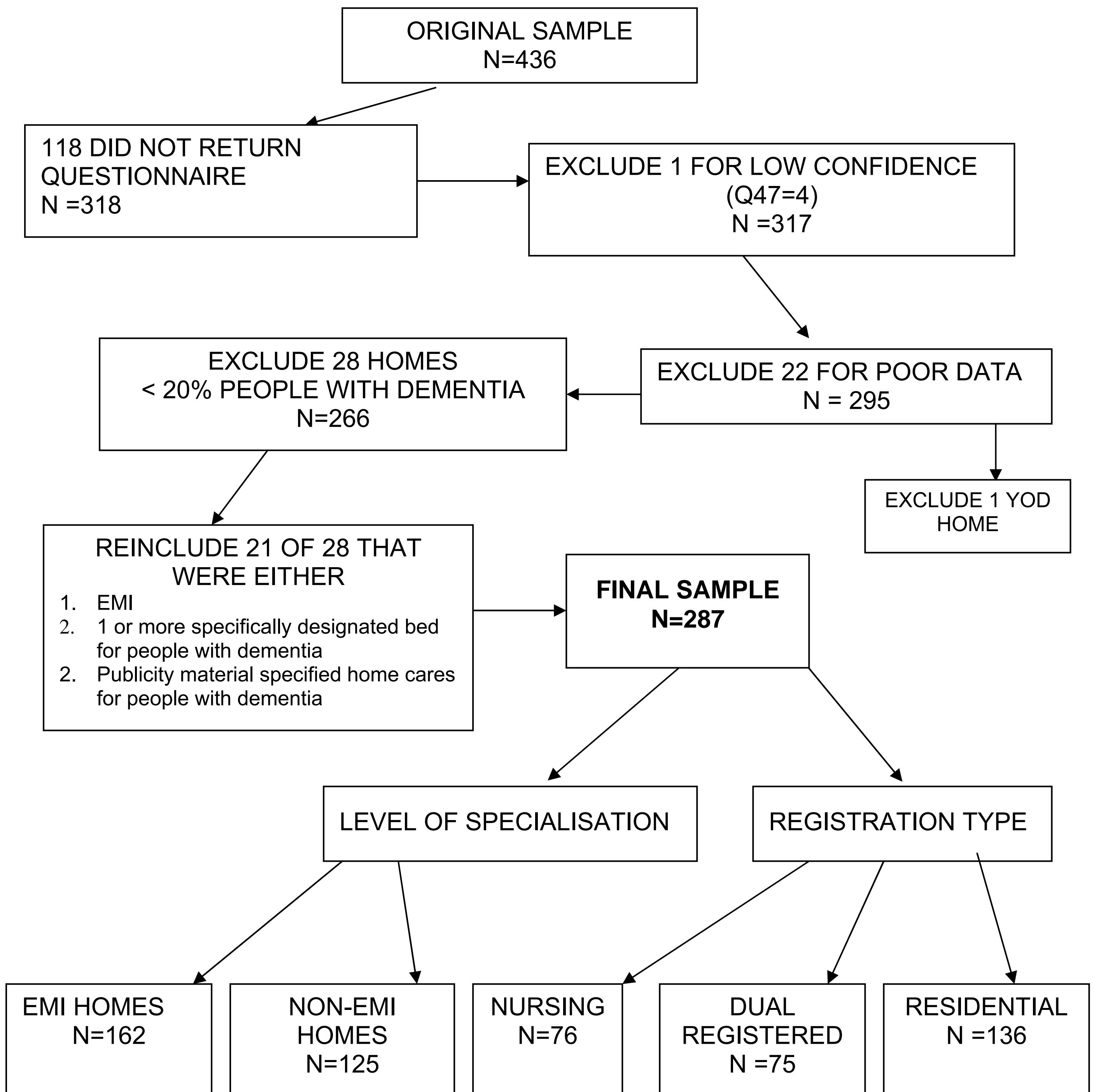
Figure 4.1: Flowchart showing calculation of sample and final sample breakdown



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4.3.1 Standards of care

A series of standards or measures of quality were developed to provide criteria by which services could be assessed. These were recorded under the four themes (identified in bold) shown in Table 4.1. Quality issues were identified through a selective literature review, which identified key themes, and through the use of The Care Homes for Older People National Minimum Standards, laid down by the National Care Standards Commission under the Care Standards Act 2000.

The measurement of each of the standards developed consisted of a combination of individual descriptive data (for example, residents can have visitors at any time) and composite variables (for example, choice). The latter were more comprehensive, being derived from multiple items and indicators within a standard. Explanations of these are found within the results section. Each positively answered item was assigned one point and these were summed to compute a composite score within each standard. In order to reduce the chances of social desirability bias, the questionnaire was deliberately not structured according to each standard in turn. Following the pilot study, a number of questions, despite yielding minimal variation, were retained in the questionnaire. It was hoped that retaining these questions, which were highly likely to yield a positive response, would encourage respondents to feel more able to admit to practices that are less positive (Oppenheim, 1966).

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Table 4.1: Themes/standards of care measured

Service configuration and standard of care data [a]	Chapters					
	Summary Page no	Literature page	Results		Discussion Box no.	Appendix 3 Figure no
			Text page no	Table no		
Service structure						
Activity rates - number places/attendees	7-8	15-16	40-43	5.9-5.12		3.1 3.2
Integration of services	8	17, 18	44-5	5.13-5.16	6.1	3.3
Funding/funding continuity		18	39-40	5.7-5.8		
Management and staffing	8	19	45 - 48	5.17-5.22	6.2-6.3	3.4
Care process						
Assessment	8	21-22	48-52	5.23-5.26	6.4	3.5 3.7
Care plans		22	50-51	5.27		3.6
Rehabilitation potential (stimulating activities)	8	23	52-55	5.30-5.32	6.5	
Equity of access to services for ethnic minorities	8	24-5	55-56	5.33	6.6	3.8
Service content						
Service specialism/ targeted at people with dementia	9	14	56-58	5.34-5.38	6.7	3.9
Promotion of early intervention [a]						
Prevention [a]						
Equity of access to specialist input		14	44-45	5.13-5.16		
Flexibility and around the clock services [a]						
Crisis response/ Emergency access [a]						
Independence - good practice & building design	9	25-6	58	5.39-5.41	6.8-6.9	3.10 3.11
Transport [a]						
Service quality						
Privacy	9	26	60-61	5.42	6.10	3.12
Individuality		13	61-62	5.43		3.13
Specialist dementia care training for staff	9	20	62-63	5.44-5.46	6.11	3.14
Carer involvement (& respite)	9	27	65-6	5.53	6.12	3.15
Care worker good practice		21	63-4	5.47-5.52		3.17
Quality assurance			67	5.55-5.56		

[a] These standards were not measured in the survey of long term care services but were measured in relation to one or more of the other three surveys: day care; home care or professional teams

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4.3.2 Data analysis and categorisation

The results are designed to describe the provision of residential services for people with dementia in the North West of England in terms of the standards outlined in Table 4.2 below. Comparisons between different service types are reported alongside findings for the whole sample. Comparisons between different individual local authority areas in the North West of England are described in relation to home type, sector, capacity, and activity levels. This includes information on numbers of ethnic minority residents. The literature review comments on most of the themes listed below.

The comparative analysis was largely between homes registered as being for the "elderly mentally infirm" (EMI) and non-EMI homes, with some designated capacity for older people with dementia, as these were considered to have face validity, as potentially offering a different service to each other, although both types of establishment provided care for people with dementia. It was also expected that EMI homes, being specialist homes for older people with mental ill health, would perform better on our measures, indicating that a better quality of care was available in these homes for people with dementia, compared with non-EMI homes. The term 'elderly mentally infirm' has been in common usage for several decades, introduced as an imprecise catch-all phrase to cover mental illnesses of many kinds among elderly people (Gray and Isaacs, 1979). Although the term is not a registration category for care homes it is used informally and is understood by home staff. Where it was considered of interest, comparisons between nursing, dual registered and residential care homes have also been reported. Comparisons have also been made between local authorities and between local authority types on a number of key indicators. These are found both in the main body of the report and in Appendix 3. Three local authority types are represented in North West England: metropolitan boroughs, counties and new unitary authorities.

Data was entered and analysed using SPSS version 10.1. Differences in the characteristics of service types and local authority types were explored using descriptive statistics. Chi Squared (χ^2) analysis was performed for categorical variables. Analysis of variance (anova) was used for normally distributed continuous variables along with the Kruskal-Wallis (3 group comparison) and Mann-Whitney U tests (2 group comparison) where this was appropriate. Statistical tests were all conducted at the 5 per cent level. Grouping variables are usually shown in table columns for cross tabulations and in table rows when comparing means. Missing data was recoded as negative where this assumption had face validity, for example, where there was no response to a question requiring a tick for a positive response. Where this assumption was not reasonable the sample size was reduced for the purpose of analysis.

The construct validity of the composite measures was tested by comparing the scores of contrasting groups (Streiner and Norman, 1991). The internal reliability of the constructs was tested by using Cronbach's alpha calculations (Sonquist and Dunkelberg, 1977). The Alpha co-efficient ranges in value from 0 to 1, with a higher score indicating greater reliability. Nunally (1978) suggested that 0.7 was an acceptable cut-off, but lower thresholds have been used in the literature (Santos,

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1999). The table below shows the Alpha co-efficient for each of the composite variables used in the present study.

Table 4.2: Alpha scores of composites

Variable	Number of items	Alpha scores
Assessment: functional domain	4	.88
Assessment: cognitive domain	3	.72
Assessment: social domain	5	.80
Assessment: clinical domain	3	.83
Systematic assessment	4	.11
Privacy	3	.17
Management good practice	6	70
Special arrangements for ethnic minorities	4	.86
Care plan meets National Service Framework for Older People criteria	3	.33
Care plan meets wider criteria	9	.50
Carer involvement	6	.26
Building features	7	.43
Good practice	6	-.05
Good practice and building features	13	.39
Rehabilitation activities	10	.49
Overall mean Alpha Score		.49

The low scores of some of the composites indicate a lack of association between the separate items within them. These composites nevertheless have validity as, although the possession of one attribute does not mean a home is more likely to possess one of the other attributes, none the less, the more attributes there are found within each composite the greater likelihood of a better quality of care. In addition Alpha scores were found to be very low, as expected, where the majority of homes answered in a similar fashion to particular measures.

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5 RESULTS

5.1 Respondents and response rates

As indicated in Figure one, the final sample was comprised of 287 homes, within an overall response rate of 73 per cent, varying between local authorities from 57 per cent to 100 per cent. Table 5.1 shows the breakdown of the response rate by local authority type. The full breakdown can be found in Table 5.2.

Table 5.1: Response rate and remaining after application of exclusion criteria by local authority type

Authority Types	Respondent mail out sample			Remain after exclusion criteria applied	
	Sent	Returned	%	n	%
Metropolitan boroughs	277	148	53	134	91
Counties	187	131	70	118	90
New unitary authorities	52	37	71	34	92
Total	436	318	73	287	91

Table 5.2: Response rate and remaining after application of exclusion criteria by local authority

Local authority	Respondent mail out sample			Remain after exclusion criteria applied	
	Sent	Returned	%	n	%
Cumbria	82	61	74	51	84
Bolton	8	6	75	6	100
Bury	3	3	100	3	100
Manchester	14	11	79	11	100
Oldham	5	5	100	5	100
Rochdale	8	8	100	6	75
Salford	7	5	71	3	60
Stockport	24	21	87	21	100
Tameside	32	24	75	20	83
Trafford	11	6	54	5	83
Wigan	8	6	75	6	100
Knowsley	5	4	80	4	100
Liverpool	19	12	63	11	92
Sefton	25	19	76	17	89
St. Helens	8	6	75	6	100
Wirral	17	12	71	10	83
Cheshire	31	24	77	24	100
Halton	7	4	57	3	75
Warrington	9	7	78	5	71
Lancashire	74	46	62	43	93
Blackburn with Darwen	22	18	82	18	100
Blackpool	14	8	57	8	100
Total	436	318	73	287	91

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5.2 Service structure

5.2.1 Home and local authority types

There were 162 homes that described themselves as specialising in the care of the elderly mentally infirm and 125 that did not. Homes were also categorised as nursing homes (n=76), dual registered homes (n=74), and residential homes (n=136). Table 5.3 shows the proportions of EMI and non-EMI homes according to the three categories of local authorities. Counties had a relatively even split between home types whilst new unitary authorities and metropolitan boroughs had a much higher proportion of EMI homes than non-EMI homes. Table 5.4 shows the proportion of nursing, dual registered and residential homes according to local authority type. There was a more even split between these types of homes across the local authority types.

Table 5.3: Home type (EMI or not) by local authority type

Authority types	EMI		Non-EMI		Total	
	n	%	n	%	n	%
Counties	57	48	62	52	119	41
New unitary authorities	25	73	9	26	34	12
Metropolitan boroughs	80	59	54	40	134	47
Total	162	56	125	43	287	100

χ^2 : p = .054

Source Question: 5: Which of the following best describes your facility?

Table 5.4: Home type (nursing, dual registered or residential) by local authority type

Authority types	Nursing		Residential		Dual registered		Total	
	n	%	n	%	n	%	n	%
Counties	25	21	59	50	35	29	119	41
New unitary authorities	8	24	16	47	10	29	34	12
Metropolitan boroughs	43	32	61	45	30	22	134	47
Total	76	26	136	47	75	26	287	100

χ^2 : p = ns

Source Question: 5: Which of the following best describes your facility?

5.2.2 Sector

Overall, most EMI homes were in the private sector (88 per cent) as were most non-EMI homes (74 per cent). Table 5.5 shows that a greater proportion of private homes were categorised as EMI (60 per cent) compared with local authority homes (52 per cent) and voluntary sector homes (29 per cent). Table 5.6 shows that the vast majority of local authority and voluntary sector homes were residential whilst the private sector had only 10 per cent more residential homes than nursing and dual registered homes.

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Table 5.5: Sector by home type (EMI or not)

Home type	EMI		Non-EMI		Total	
	n	%	n	%	n	%
Private	142	60	93	40	235	100
Local authority	11	52	10	48	21	100
Voluntary/not for profit	9	29	22	71	31	100
Total	162	56	125	44	287	100

χ^2: p = .061

Source Question: 4: Within which sector does your service operate?

Table 5.6: Sector by home type (nursing, residential or dual registered)

Home type	Nursing		Residential		Dual		Total	
	n	%	n	%	n	%	n	%
Private	71	30	93	40	70	30	235	100
Local authority	1	5	17	81	3	14	21	100
Voluntary/not for profit	4	13	26	84	1	3	31	100
Total	76	26	136	47	74	26	287	100

χ^2: p = <.001

Source Question: 4: Within which sector does your service operate?

5.2.3 Funding

Table 5.7 shows the proportion of residents funded from different sources. As expected, the vast majority of residents were funded by local authority social service departments. The mean proportion for those funded by the latter was 74 per cent irrespective of home type. The spread was not affected by the type of home, with all types falling close to this mean.

Table 5.7: Mean proportion (per cent) of all residents funded by different sources

Resident type	%
Residents funded by social services departments	74
Residents self funded	18
Residents funded by NHS	2
Residents funded by other methods	3

Source Question: 21: Please estimate the proportion of all residents who are funded by…

Table 5.8 shows the contractual arrangements for those who are not self-funded. By far the most common contractual arrangement for people with dementia who are not self-funded – the vast majority of residents – was the ‘service agreement with spot purchase’. Ninety per cent of care homes had this type of contractual arrangement irrespective of the type of home they lived in. There was no statistical difference between any of the home types.

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Table 5.8: Most common contractual arrangements for people with dementia who are not self-funded

Form of contract	n	%
Service agreement with spot purchase	241	90
Block contract	20	7
Other	6	2

Source Question: 20: What is the most common contractual arrangement for those placements for people with dementia that are not self-funded?

5.2.4 Capacity and occupancy/Activity rates

Respondents were asked about the numbers of beds in their homes, the number currently occupied and the number of beds specifically designated for people with dementia. Homes ranged in size from three to 180 places. The mean number was 36. Table 5.9 shows that EMI homes had fewer places than non-EMI homes (34 and 39 respectively) although this difference was not statistically significant. The mean number of beds for people with dementia in non-EMI homes was 14. The occupancy rate of approximately 90 per cent was broadly similar across local authority types, with metropolitan authorities having a slightly lower occupancy rate than county and unitary authorities (Table 5.10). A full breakdown of these figures for each individual local authority can be found in the Appendix 1 (Table A2*).*

Table 5.9: Mean number of total beds by home type

Home type	n	Mean	Standard deviation
EMI	162	34	21.6
Non-EMI	125	39	28.1
Total	287	36	24.7

Anova: p = ns

Source Question: 8: How many places/beds are there in this home (in total)?

Table 5.10: Total places and occupied places by local authority type

Local authority type	Total places	Places currently occupied	Occupancy rate (%)
Counties	4172	3766	90
New unitary authorities	813	739	91
Metropolitan boroughs	5395	4751	88
Total	10380	9256	89

Source Question: 9: How many places are currently occupied today?

EMI beds in non-EMI homes were calculated directly from the questionnaire responses. Respondents were asked to report the number of this type of 'bed' in their home. For EMI homes this calculation is based on the total beds in these homes. There will, of course, be a proportion of beds in EMI homes that are not currently used by people with dementia. The figures therefore represent the maximum possible places as opposed to the places currently occupied by people with dementia. Table 5.11 shows the different proportion of beds available in EMI and Non-EMI homes for people with dementia across the different local authority types. Almost a quarter of all EMI beds are to be found in non-specialist establishments (23 per cent). County authorities have a higher percentage of

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specifically designated beds for people with dementia in non-EMI homes (27 per cent) than either new unitary authorities (17 per cent) or metropolitan boroughs (22 per cent). The new unitary authorities had the highest percentage of beds for people with dementia in EMI homes (83 per cent).

Table 5.11: Number of beds for people with dementia in EMI and non-EMI homes by local authority type

Local authority types	EMI		Non-EMI		Total	
	n	%	n	%	n	%
Counties	2102	38(73)	769	46(27)	2874	40
New unitary authorities	580	10(83)	121	7(17)	701	10
Metropolitan boroughs	2840	51(78)	786	47(22)	3626	50
Total	5525	100(77)	1676	100(23)	7201	100

Row per cent in brackets

Source Questions: 5: Which of the following best describes your facility?; 6: For homes not designated as a specialist EMI establishment, how many of your places are specifically designated for people with dementia?; 8: How many places/beds are there in this home in total?

In order to obtain estimates of the proportion of the population with dementia in long term care facilities and the availability of such places, dementia prevalence rates were combined with population figures for each of the local authority areas in North West England and data relating to the availability of long term care places from the current study. The most recent population figures available were obtained from KIGS (Department of Health, 2002). The total number of long term care places, the number of long term care places designated for people with dementia, and the total occupied places, were derived from data obtained in the present study. The estimated population with dementia was then calculated as a proportion (9.3 per cent) of the population. By combining this figure with EMI places identified by the present study it was possible to estimate the proportion of EMI places in homes for older people in North West England as a percentage of the total population over 65 years with dementia. This rate was then adjusted according to the response rate achieved in the region to provide a projected figure estimating the rate per 1000 that would be expected, had 100 per cent response rate been achieved. The rate of EMI places per 1000 is therefore expressed as a range, where the lower figure relates to the actual figure obtained and the higher figure to the rate expected if a 100 per cent response rate had been achieved. In the case of regions where a 100 per cent response rate was achieved, only one figure is given. These findings are detailed in Table 5.12.

The number of EMI beds per 1,000 ranges from 1.1 to 23.7 across local authorities. The table indicates that just over 100,000 people in the North West of England are estimated to have dementia and that between 7.2 and 9.5 per cent of these people are living in residential care. Ten local authorities have more than this figure whilst five have below five per thousand.

On the basis of these figures, the results demonstrate that there are specialist beds (either in EMI homes or in non-EMI homes) for between 7 per cent and 10 per cent of the population of the North West of England who are estimated to have dementia

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(and approaching one per cent of all people in the North West over the age of 65 years). Seventy-seven per cent of these beds are in specialist EMI homes with the remaining 23 per cent in non-EMI establishments.

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Table 5.12: EMI residential and nursing home places in each local authority in the North West of England

Local authority	Dementia designated places	Places in EMI homes	Total actual EMI places	Percentage of non respondents	Total EMI places non response	Adjusted EMI places (recorded + estimated from non respond-ents)	Population over 65 years	EMI places rates per 1000 (recorded)	EMI places rates per 1000 (estimated)	Estimated prevalence of dementia based on 9.3% (Hofman et al., 1991)	Total (recorded) EMI places as a % of estimated no. of people with dementia	Total (estimated) EMI places as a % of estimated no. of people with dementia
Column key	1	2	3	4	5	6	7	8	9	10	11	12
Local authority												
Cumbria	255	449	704	0.26	183	887	88141	8.0	10.1	8197	8.6	10.8
Bolton	129	73	202	0.25	51	253	39314	5.1	6.4	3656	5.5	6.9
Bury	94	134	228	0	198	426	26177	8.7	16.3	2434	9.4	17.5
Manchester	78	407	485	0.21	102	587	56797	8.5	10.3	5282	9.2	11.1
Oldham	5	107	112	0	0	112	30908	3.6	3.6	2874	3.9	3.9
Rochdale	64	148	212	0	0	212	29338	7.2	7.2	2728	7.8	7.8
Salford	39	25	64	0.29	19	83	36302	1.8	2.3	3376	1.9	2.4
Stockport	44	351	395	0.13	51	446	47878	8.3	9.3	4453	8.9	10.0
Tameside	105	117	222	0.25	56	278	32310	6.9	8.6	3005	7.4	9.2
Trafford	38	64	102	0.46	47	149	34945	2.9	4.3	3250	3.1	4.6
Wigan	53	93	146	0.25	37	183	43439	3.4	4.2	4040	3.6	4.5
Knowsley	0	157	157	0.2	157	314	21034	7.5	14.9	1956	8.0	16.1
Liverpool	30	298	328	0.37	121	449	67387	4.9	6.7	6267	5.2	7.2
Sefton	17	390	407	0.24	98	505	54405	7.5	9.3	5060	8.0	10.0
St Helens	90	81	171	0.25	43	214	27024	6.3	7.9	2513	6.8	8.5
Wirral	0	395	395	0.29	115	510	57384	6.9	8.9	5337	7.4	9.5
Cheshire	100	613	713	0.26	185	898	108936	6.5	8.2	10131	7.0	8.9
Warrington	0	138	138	0.22	30	168	26771	5.2	6.3	2490	5.5	6.8
Halton	12	0	12	0.43	5	17	15452	0.8	1.1	1437	0.8	1.2
Lancashire	414	1043	1457	0.38	554	2011	187590	7.8	10.7	17446	8.4	11.5
Blackburn	94	283	377	0.18	68	445	18759	20.1	23.7	1745	21.6	25.5
Blackpool	15	159	174	0.43	171	345	28752	6.1	12.0	2674	6.5	12.9
Total	**1676**	**5525**	**7201**	**0.24**	**2289**	**9490**	**1079043**	**6.7**	**8.8**	**100351**	**7.2**	**9.5**

See overleaf for how figures were calculated.

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COLUMN KEY for Table 5.12

1. Beds specifically designated for people with dementia in non-EMI homes.
2. Beds in EMI homes.
3. Sum of columns 1 & 2
4. Per cent of non-respondents (see table 5.1).
5. Column 4 X column 3 / 100
6. Sum of columns 3 & 5.
7. KIGS (DOH, 2002)
8. (Column 3 / column 7) X 1000
9. (Column 6 / column 7) X 1000
10. 9.3% of column 7
11. (Column 3 / column 10) X 100
12. (Column 6 / column 10) X 100

5.2.5 Integration

Integration has been considered in relation to how often outside professionals and specialists visit a home in order to measure the extent to which homes had regular contact with services in the community. The same measure has also been considered in relation to the nature of access to specialist provision outside the home.

Table 5.13: Outside professionals visiting regularly – by home type

Profession	EMI		Non-EMI		Total		p value
	n	%	n	%	n	%	
General practitioner	118	73	102	82	221	77	ns
Community nurse	56	35	77	62	133	46	<.01
Social worker/care manager	57	35	48	38	106	37	ns
Community psychiatric nurse	44	27	33	26	78	27	ns
Old age psychiatrist	40	25	24	19	64	22	ns
Physiotherapist	23	14	20	16	43	15	ns
Occupational therapist	14	9	12	10	26	9	ns
Speech therapist	5	3	7	6	12	4	ns
Total	162	100	125	100	287	100	

Source Question: 38: Which of the following outside specialists visit your establishment and how regularly?

Respondents were given a list of ‘outside professionals’ who might visit their home. Table 5.13 shows how these were distributed. By far the most frequently cited regular visitor was the general practitioner. The least frequent regular visitors cited were the speech therapist, and the occupational therapist.

Respondents were asked how many professionals visited their home on a regular basis, defined as once a month or more. Responses ranged from zero to eight with the mean for all homes being 2.9. Twenty-eight homes, 10 per cent, stated that no outside professionals visited regularly; 17 of these were EMI homes compared with 11 non-EMI homes. Table 5.14 shows the mean number of professionals visiting on a regular basis for EMI and non-EMI homes. A slightly higher mean is seen for non-EMI homes. When the number of homes regularly having three or more visits from outside professionals was measured a slightly different result emerged (see Table 5.15) with a significant difference being found between EMI and non-EMI homes. Fifty-one per cent of EMI homes fulfilled this criteria compared with 63 per cent of non-EMI homes.

Table 5.14: Mean number of different professionals visiting regularly by home type (max score =8)

Home types	n	Mean	Standard deviation
EMI	162	2.7	1.63
Non-EMI	125	3	1.60
Total	287	2.9	1.63

Anova: p = .054

Source Question: 38: Which of the following outside specialists visit your establishment and how regularly?

Table 5.15: Three or more professionals visiting regularly by home type (EMI and non-EMI)

Measures of integration	EMI (n=162)		Non-EMI (n=125)		Total (n=287)		
	n	%	n	%	n	%	p value
Three or more different professionals visit regularly	82	51	79	63	161	56	.033
Integration scores [mean (SD)]	5.1 (0.50)		6.3 (0.48)		5.6 (0.49)		.033

Source Question: 38: Which of the following outside specialists visit your establishment and how regularly?

Respondents were also asked if they had contact with specific dementia services in their area. Forty per cent, 113 homes, stated that they did and 90 of these provided details. The most commonly mentioned specialist dementia services are detailed in Table 5.16 below. EMI homes were significantly more likely to be in touch with their local Alzheimer's Society than were non-EMI homes. Non-EMI homes, on the other hand, were significantly more likely to be in touch with a specialist community team.

Table 5.16: Local dementia specialist services with which homes had contact

Specialist service	EMI		Non-EMI		Total		p value
	n	%	n	%	n	%	
Alzheimer's Society	31	57	11	31	47	37	.011
Specialist community team	13	24	18	50	34	27	.029
Other voluntary organisation	10	19	7	19	17	19	ns
Total	54	100	36	100	90	100	

Source Question: 39: Do you have contact with a specific dementia service in your area?

5.2.6 Management and staffing

Managers' qualifications

In the current sample seven per cent (20) of managers possessed no relevant qualifications. Another five per cent (14) had only NVQ level two or NVQ level three. Twenty-six per cent had NVQ level four. There was a slight difference between EMI and non-EMI homes in relation to NVQ level 4 with 24 per cent of managers in the former and 29 per cent of managers in the latter fulfilling this brief. The difference was not statistically significant.

Most homes (62 per cent) were managed by a nurse. EMI homes had a greater number of managers with nursing qualifications than did non-EMI homes (Table 5.17). When this was explored further it was evident that this difference applied only to the category of 'registered mental nurse' with thirty-six per cent of EMI homes

(n=58) and 17 per cent (n=21) of non-EMI homes having this type of manager (χ^2 : p =<.01). As would be expected, nursing and dual registered home managers were more likely to have a nursing qualification than were residential home managers. Ninety-seven per cent of nursing homes and 84 per cent of dual registered homes had managers with a nursing qualification compared with 29 per cent of residential homes (Table 5.18). Twenty per cent of all homes had a manager without either a level four NVQ or a nursing qualification. This was the case in significantly more non-EMI homes (26 per cent) compared with EMI homes (15 per cent) and residential homes (38 per cent) compared with nursing (3 per cent) and dual registered homes (5 per cent).

Table 5.17: Managers with nursing qualification in EMI and non-EMI homes

Qualification	EMI		Non-EMI		Total		
	n	%	n	%	N	%	p value
Nursing	113	70	64	51	177	62	.001
Nursing, NVQ4, or DipSW	137	86	92	74	229	80	.022
Total	162	100	125	100	287	100	

Source Question: 23: Do you (the manager) have any of the following qualifications…?

Table 5.18: Managers with nursing qualifications in residential, nursing and dual registered homes

Qualification	Nursing		Residential		Dual		Total		
	n	%	n	%	n	%	n	%	p value
Nursing	74	97	40	29	63	84	178	62	.001
Nursing, NVQ4, or DipSW	74	97	84	62	71	95	229	80	.001
Total	76	100	136	100	75	100	287	100	

Source Question: 23: Do you (the manager) have any of the following qualifications…?

Qualified and unqualified staff groups employed

Homes employed a range of care staff and the proportions of these varied according to the type of home: residential, dual registered or nursing; EMI or non-EMI. Table 5.19 shows the total number of homes employing the various staff groups in homes with the figures analysed in terms of specialist and non-specialist provision. Overall, 60 per cent of homes employed no qualified nursing staff. EMI homes employed a significantly higher percentage of nurses, both registered general nurses and registered mental nurses, than did non-EMI homes. Table 5.20 shows the breakdown of staff groups employed in nursing, residential and dual registered homes. Over 80 per cent of nursing homes had some qualified nursing care staff (as well as their manager) compared to 63 per cent of dual registered homes and 4 per cent of residential homes.

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Table 5.19: Number of homes employing staff groups – by EMI and non-EMI home

Staff group	EMI		Non-EMI		Total		
	n	%	n	%	n	%	p value
RGN	89	55	53	42	142	49	.035
RMN	93	57	39	31	133	46	<.001
Any qualified nurse	78	48	37	30	115	40	.001
Senior care staff	131	81	107	86	238	83	.053
Care assistants	153	94	122	97	276	96	ns
Social work staff	5	3	7	6	12	4	ns
Activity staff	67	41	49	39	116	40	ns
Total	162	100	125	100	287	100	

Source Question: 26: Within the table below, please complete the three questions for each of the six groups of staff/ How many whole/full time equivalent staff are there?

Table 5.20: Number of homes employing staff groups – by residential, nursing and dual registered home

Staff group	Nursing		Residential		Dual registered		Total		
	N	%	N	%	N	%	N	%	p value
RGN	68	89	19	14	55	73	142	49	<.001
RMN	67	88	14	10	51	68	132	46	<.001
Any qualified nurse	62	82	6	4	47	63	115	40	<.001
Senior care staff	51	67	123	90	64	85	238	83	ns
Care assistants	73	96	131	96	71	95	275	96	<.001
Social work staff	1	1	9	7	2	3	12	4	<.001
Activity staff	46	60	30	22	40	53	116	40	<.001
Total	76	100	136	100	75	100	287	100	

Source Question: 26: Within the table below, please complete the three questions for each of the six groups of staff/ How many whole/full time equivalent staff are there?

Tables 5.21 and 5.22 below show the numbers of whole time equivalent qualified nursing staff, unqualified care staff, and total staff in relation to every ten residential places. The tables both indicate that for every ten residents there was, on average, one qualified nurse and seven non-nursing care staff employed, i.e. four members of staff employed per five residents. Nursing homes had a higher mean in relation to qualified staff (2:10). It is important to note that these figures refer to total staff employed and will be reduced to take account of shift patterns, sickness and holidays.

Table 5.21: Numbers of staff employed to every ten beds (nursing, residential or dual registered homes)

Home types	Total staff to each 10 occupied places		Qualified staff to each 10 occupied places		Unqualified staff to each 10 occupied places	
	Mean	SD	Mean	SD	Mean	SD
Nursing (n=76)	9	6.01	2	1.40	6	3.34
Residential (n=136)	9	6.07	1	.43	8	5.02
Dual (n=75)	10	6.87	2	2.05	7	5.30
Total (n=287)	9	6.27	1	1.58	7	6.93
Anova	p = ns		p = <.001		p = .015	

Source Questions: 26: Within the table below, please complete the three questions for each of the six groups of staff/ How many whole/full time equivalent staff are there?; Q8: How many places are available in total; Q9: How many places are currently occupied?

Table 5.22: Numbers of staff employed to every ten beds (EMI and non-EMI)

	Total staff to each 10 occupied places		Qualified staff to each 10 occupied places		Unqualified staff to each 10 occupied places	
	Mean	SD	Mean	SD	Mean	SD
EMI (n=162)	9	5.70	1.32	1.71	7	4.10
Non-EMI n=125)	9	6.96	0.83	1.34	8	5.50
Total (n=287)	9	6.27	1.10	1.58	7	4.78
Anova	p = ns		p = .009		p = ns	

Source Questions: 26: Within the table below, please complete the three questions for each of the six groups of staff/ How many whole/full time equivalent staff are there?; Q8: How many places are available in total?; Q9: How many places are currently occupied?

5.3 Care process

5.3.1 Systematic assessment and care planning

Assessment

Homes were asked a series of questions about their assessment and care planning tools and practices. They were also asked *either to* send in their assessment and care planning forms together with the completed questionnaire *or,* where this was not possible, to complete a number of more detailed questions on the questionnaire itself. Where forms were received (102 assessment documents and 86 care planning forms) they were post-coded by the researchers and these data were analysed.

Seventy-eight per cent (225) of homes stated that they completed an assessment form for people with dementia in the first three months following admission to their home. Slightly more EMI homes, 82 per cent (132), compared with non-EMI homes, 74 per cent (92) fulfilled this criterion but the difference was not statistically significant.

Service user assessments were measured using four assessment domains identified by previous research (Stewart et al., 1999): functional, cognitive, social, and clinical-medical. Documents submitted by care homes varied in terms of the extent to which they incorporated these domains. Table 5.24 shows the percentage scores for homes covering one or more sections. Fifty-eight per cent of all homes covered all four sections of the functional domain whilst 48 per cent did so for the clinical domain. Forty-five per cent of homes covered all three sections of the cognitive

domain. Only 2 per cent covered all five sections of the social domain. Between 20 and 23 per cent of all homes did not cover any section of at least one domain. The content of each of these and the percentage of homes reporting that they completed each section is detailed in Table 5.23 below.

Table 5.23: Assessment domains covered by homes

Functional (4 items)	%	Cognitive (3 items)	%	Social (5 items)	%	Clinical (4 items)	%
Continence	78	Daily routine/preferences	68	Social/recreational activity	71	Teeth and Nutrition	70
Mobility and ADL	77	Depression/anxiety/ mood state	66	Religious observance	63	Medication	70
Communication /hearing patterns	74	Cognitive patterns	55	Participation in assessment	45	Disease/ health conditions	62
Vision patterns	60			Carer supported	40	Skin and foot care	59
				Familiar cultural traditions	11		

Source Question: 29: Does your assessment form specify the following (tick relevant boxes)?

Table 5.24: Number of items in assessment domains covered by homes (n=225)

Scores	Functional (4 items)	Cognitive (3 items)	Social (5 items)	Clinical (4 items)
	%	%	%	%
0	20	22	23	21
1	2	9	12	6
2	5	24	12	11
3	15	45	20	15
4	58	-	32	48
5	-	-	2	-

Source Question: 29: Does your assessment form specify the following…?

In four of the sixteen assessment areas significant differences were found between EMI and non-EMI homes in relation to domains of assessment specified in assessment documentation. Three of the four were in the social-environmental domain and one was in the clinical domain. In all these cases non-EMI homes scored more highly. It would seem that non-EMI homes placed more emphasis on social and environmental characteristics in their assessments – and on medication – than EMI homes. User participation in assessments also came close to significance. The findings (including user participation) are detailed below in Table 5.25. The mean number of items assessed in each of the four domains was also compared between EMI and non-EMI homes. In line with the results above, non-EMI homes had a significantly higher mean score compared with EMI homes on the social-environmental domain (Table 5.26).

Table 5.25: Assessment documentation: significant differences in specified domains between EMI and non-EMI homes

Assessment domains	EMI %	Non-EMI %	p value
Social/recreational activity	65	79	.021
Religious observance	58	71	.046
Carers needs/support given	34	48	.039
Resident participation in assessment	40	53	.053
Medication	64	78	.019

Source Question: 29: Does your assessment form specify the following (tick relevant boxes?

Table 5.26: Assessment domains, mean scores for EMI and non-EMI homes

Assessment domains	EMI (n=132)		Non-EMI (n=92)		Total (n=224)		
	Mean	SD	Mean	SD	Mean	SD	p value
Functional	2.8	1.65	3.0	1.49	2.9	1.59	ns
Clinical	2.5	1.65	2.8	1.59	2.6	1.61	ns
Social	2.1	1.62	2.6	1.54	2.3	1.60	.015
Cognitive	1.9	1.23	1.9	1.14	1.9	1.19	ns

Source Question: 29: Does your assessment form specify the following (tick relevant boxes?

Care plans

Respondents were asked whether they made a care plan for each service user following an assessment, whether these were sent to relatives, and whether they involved care/nursing assistants in care planning meetings. Ninety-six per cent of the 225 respondents, who stated that they completed an assessment following admission, reported that they also completed a written care plan following an assessment. This represents 75 per cent (n=215) of the whole sample (n=287). However, only 9 per cent of these (n=9) routinely sent copies to relatives. Fifty per cent (n=108) of respondents reported that they routinely involved care/nursing assistants in care planning meetings. Very little difference was found between home types. Regardless of whether the home completed their own assessment of new residents, 89 per cent of homes stated that they completed a care plan for them (see Table 5.29).

Eighty-six care plan forms were returned. The individual care plan content outlined in the National Service Framework for Older People (Department of Health 2001b) was used as the framework for analysis. This includes the need for care plans to include descriptions of objectives (goals), outcomes of care provision and detail about the care to be provided (interventions). They were also considered in relation to additional content. This is detailed in Table 5.27 below. Most homes that returned care plan documentation covered at least one of the criteria outlined in the NSFOP. Sixty-nine per cent met all three of the NSFOP criteria, specifying ‘problems’, ‘goals’, and ‘interventions’ needed to achieve them. The mean score was 2.6 (max=3). Only nineteen per cent of homes met all of the more rigorous criteria, outlined in Table 5.26. The mean score was 6.5 (max=9). There was no difference between home types.

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Table 5.27: Care plan content (n=86)

Care plan content		%
NSFOP requirements	Structure, description of problem	99
	Objectives outcomes	78
	Level and type of support	89
Additional content	Care plan based on assessment of need	96
	Date for when problem/need identified	86
	Date for review	75
	Enough space to write comprehensive care plan	67
	Signature for when problem/need was identified	49
	Signature for when care plan actioned	36
	Composite mean (Max=9)	6.5 (SD = 2.01)

Source: Care Plan Post Coding Sheet

Reviews

Respondents were asked how frequently they carried out reviews on the care needs of their residents. The results can be seen in Table 5.28. Of the 138 homes in the sample that responded to this question, 49 per cent said that they carried out reviews at three monthly or more frequent intervals. No difference was found between home types. If the total sample is included and those not responding to the question are assumed to be carrying out reviews less frequently than three monthly, the figure plummets to 24 per cent. Respondents were also asked whether relatives or carers were routinely asked to attend reviews. This was the case in 73 per cent (203) of homes. Non-EMI homes were more likely to routinely invite carers to attend reviews (77 per cent, 96) compared to EMI homes (66 per cent, 107) (χ^2 = p .047).

Table 5.28: Timing of reviews

Frequency of reviews	Responses (n=138)		Total sample (n=287)	
	n	%	n	%
More than 3 monthly	68	49	68	24
Less than 3 monthly	70	51	219	76

Source Question: 33: Do you have a planned review of each resident (in addition to those conducted by the social services department? If yes, how often do you undertake this review?

Systematic assessment and care planning practices

A number of variables were combined to produce a measure of systematic assessment and care planning. This included a written assessment within three months of admission, the regular making of care plans, the routine involvement of carers in reviews and the holding of these more than three monthly. Each of these contributory practices were measured separately in their respective sections and are brought together in Table 5.29 below. When combined to form a composite variable the differences between home types found in the individual variables were masked. All homes shared the mean of 2.9 out of a maximum score of 4.

Table 5.29: Systematic assessment and care planning practices by home type EMI or not

Care planning practice	EMI		Non-EMI		Total		p value
	n	%	n	%	n	%	
Written assessment in first 3 months after admission	132	81	92	74	224	78	ns
Care plan made	150	93	107	86	257	89	.055
Review more than 3 monthly	35	22	33	26	68	24	ns
Carers routinely invited to reviews	107	66	96	77	203	70	.047
Systematic assessment composite (max=4) [mean (SD)]	2.9 (.85)		2.9 (.90)		2.9 (.87)		ns

Source Questions: 28: Do you complete an assessment form on people with dementia in the first three months after they are admitted?; 30: Do you make a care plan for each service user as a result of this assessment?; 33: Do you have a planned review?; 34: Do you routinely invite relatives/carers to your reviews?

5.3.2 Rehabilitation

Ten factors were considered in relation to the promotion of rehabilitation. Overall, 27 per cent of homes employed a member of staff to run reminiscence, reality reorientation, or other activities. Just below 40 per cent of homes had a specially designed garden. Eleven per cent had a specific reminiscence room. Eighty-nine per cent stated that they offered residents the opportunity to take part in activities that were part of their life-style prior to admission. Just below half (49 per cent) offered additional specialist help for people with sensory impairment. The individual results are listed in Table 5.30 below along with the composite mean for all homes, EMI, and non-EMI homes. The composite mean was 4 for all homes out of a maximum possible score of 10, with little difference between EMI and non-EMI homes. When measured individually EMI homes scored more highly than or equal to non-EMI homes on all but one of the above categories: three or more different professionals visiting regularly. Statistically significant differences in favour of EMI homes were found in relation to two variables; members of staff employed to run reality orientation activities and the presence of a Snoezelen room. Sixteen per cent (26) of EMI homes compared to 6 per cent (8) of non-EMI homes had this facility.

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Table 5.30: Factors that might influence rehabilitation in EMI and non-EMI homes

Resources	EMI (n=162)		Non-EMI (n=125)		Total (n=287)		p value
	n	%	n	%	n	%	
Residents encouraged to take part in everyday activities	140	89	106	90	246	89	ns
Activity and exercise	132	82	90	72	223	77	ns
3 or more different professionals visit regularly	82	51	79	63	161	56	.033
Additional help for sensory impairment	63	50	47	48	110	49	ns
Member of staff to run reminiscence activities	70	43	47	38	117	41	ns
Specially designed garden	64	39	47	38	111	39	ns
Member of staff to run reality orientation activities	44	27	20	16	64	22	.024
Member of staff to run other activities	34	21	16	13	50	17	ns
Snoezelen room	26	16	8	6	34	12	.012
Reminiscence room	22	14	10	8	32	11	ns
Composite mean [mean (SD)]	4.2 (1.85)		3.8 (1.70)		4(1.80)		ns

Source Questions: 7: Does your building have any of the following special design features for people with dementia?; 38: Which of the following outside specialists visit your establishment and how regularly?; 41: Are people with dementia offered the opportunity to take part in everyday activities?; 42: Does your home employ a member of staff to run structured activities for residents with dementia in any of the following?; 43: Does your home employ any of the following methods or approaches for people with dementia?; 46: For residents with dementia do you provide any additional specialist help for sensory impairment?

Factors that promote rehabilitation were also measured in relation to whether homes were residential or nursing/dual registered. Differences were found between these categories in relation to reminiscence rooms and staff. Table 5.31 shows the individual results and composite mean.

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Table 5.31: Factors that might influence rehabilitation in residential, dual registered and nursing homes

Resources	Nursing (n=76)		Residential (n=136)		Dual (n=75)		Total (n=287)		p value
	N	%	N	%	n	%	N	%	
Residents encouraged to take part in everyday activities	64	84	116	85	66	88	247	86	ns
Activity and exercise	59	78	104	76	59	79	223	77	ns
3 or more different professionals visit regularly	41	54	79	58	41	55	162	56	ns
Member of staff to run reminiscence activities	41	54	39	29	37	49	117	41	<.001
Specially designed garden	33	43	52	38.	26	35	112	39	ns
Additional help with sensory impairment	30	40	50	37	30	40	110	38	ns
Member of staff to run Reality Orientation activities	30	39	21	15	13	17	64	22	ns
Member of staff to run other activities	20	26	12	9	18	24	50	17	ns
Snoezelen room	17	22	7	5	10	13	35	12	ns
Reminiscence room	13	17	8	6	11	15	32	11	<.001
Rehabilitation Composite [mean (SD)]	4.6(1.93)		3.6(1.64)		4.1(1.74)		4.0(1.79)		<.001

Source Questions: 7: Does your building have any of the following special design features for people with dementia?; 38:which of the following outside specialist visit your establishment and how regularly?; 41: Are people with dementia offered the opportunity to take part in everyday activities?; 42: Does your home employ a member of staff to run structured activities for residents with dementia in any of the following?; 43: Does your home employ any of the following methods or approaches for people with dementia?; 46: For residents with dementia do you provide any additional specialist help for sensory impairment?

5.3.3 Activities

Respondents were asked whether their residents with dementia were given the opportunity to take part in everyday activities that were part of the person's lifestyle prior to their admission. Eighty-six per cent of homes responded positively to this question. These homes were then asked to give an example of activities available to residents and these were categorised, by the researchers, according to whether they were group or individually based. A maximum of nine types of activities were coded for each category. Fifty-one per cent (147) of homes responded to this question. The examples given by homes of the activities they offered are listed in Table 5.32. No statistically significant differences were found between home types

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Table 5.32: Examples of activities offered by homes (n=98)

Individual activities			Group activities		
	n	%		n	%
Light housework	53	36	Day outings	38	26
Playing cards or games'	20	14	Home outing	23	16
Houseplants or gardening	20	14	Outside clubs and pub visits	18	12
Sewing or knitting	8	5	Church service in home	14	9
Watching TV	7	5	Church	14	9
Hairdressing	7	5	Music and movement or dance	12	8
Craftwork	5	3	Other physical exercise	7	5
Reading	3	2	Home clubs	4	3
Jigsaws	2	1	Group therapy	2	1

Source Question: 41: Are people with dementia offered the opportunity to take part in everyday activities which were part of the person's lifestyle prior to admission? If yes, please give an example

It should be noted that homes were asked to give examples of activities offered. The results outlined here are based on the assumption that these are *all* the activities offered, which is likely to be overly conservative. However, the distribution of types of activity, and the presence/absence of activity remain important evidence.

5.3.4 Equity of access to services for minorities

Respondents were asked to specify how many of their current residents were from ethnic minority groups. Forty-six homes, 16 per cent, had one or more residents from an ethnic minority group. Half of these had just one resident. There were a total of 92 residents from ethnic minorities, just under one per cent of the total/occupied places and approximately one third of the expected figure, given that ethnic minorities over the age of 65 accounted for 2.7 per cent of the population of North West England (2001 Census). A full breakdown of these figures can be found in Appendix 2. It is not possible to assess from these data how many ethnic minority elders with dementia are within this sample.

Respondents were asked to outline the special arrangements they had made for people from ethnic minority groups. In particular, questions were asked about religious observance and spirituality, language resources, food, and personal care. The results for all homes and for EMI and non-EMI homes are shown in Table 5.33. Approaching one third of homes said that they made special arrangements regarding food for people from ethnic minority groups. Less than one quarter had any special arrangements in place for religious observance. Nineteen per cent had such arrangements in place for personal care. Only 10 per cent had any such special arrangements in relation to language needs. Sixty seven per cent of all homes had no special arrangements whilst seven per cent (20 homes) provided all four services. Of these, nine per cent (15) were EMI homes and four per cent (5) were non-EMI homes.

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Table 5.33: Homes offering special arrangements for ethnic minority groups

Special arrangements	EMI	%	Non-EMI	%	Total	%	p value
Religious observation	42	26	23	18	65	23	ns
Language resources	21	13	9	7	30	10	ns
Food	52	32	37	30	89	31	ns
Personal care	35	22	21	17	56	19	ns
Composite [mean (SD)]	1(1.42)		0.7(1.22)		0.8(1.34)		ns

Source Question: 45: Have you made any of the following special arrangements for people from ethnic minority groups…?

When combined the mean scores for all homes providing one or more of the above services was 0.8 out of a maximum of four. EMI homes scored slightly higher than non-EMI homes but the difference was not statistically significant.

5.4 Service content

5.4.1 Targeting service for people with dementia

Service users: Percentage of people with dementia

Table 5.34 shows the proportion of people with dementia cared for within the various home types. Fifty-five per cent of homes (159) cared for over 60 per cent of people with dementia whilst over 40 per cent stated that they cared for between 81 and 100 per cent people with dementia including 17 (14 per cent) non-EMI homes. Unsurprisingly EMI homes have a significantly greater percentage of people with dementia than do non-EMI homes. Sixty-four per cent of EMI homes cared for between 81 per cent and 100 per cent people with dementia. Seventy-seven per cent (125) of these homes had over 60 per cent of their residents with dementia compared with 28 per cent (35) of non-EMI homes. There was also a substantial minority of EMI homes, 23 per cent, (37) whose resident population was made up of less than 60 per cent people with dementia. Over half of these (20 homes, 12 per cent) had between 41 per cent and 60 per cent of their residents with dementia.

Statistically significant differences were also found in between residential, dual registered and nursing homes in relation to the percentage of residents with dementia and these are outlined in Table 5.35. Seventy-five per cent of nursing homes had over 60 per cent of their residents with dementia compared with 48 per cent of residential homes and 49 per cent of dual registered homes.

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Table 5.34: Homes caring for greater than or less than 60 per cent people with dementia

People with dementia	EMI		Non-EMI		Total	
	n	%	n	%	n	%
Under 60%	37	23	90	72	127	44
Over 60%	125	77	35	28	159	55
Total	162	100	125	100	287	100

χ^2 : p =< .001

Source Question: 1: Please estimate the approximate percentage of your residents who suffer from dementia or are confused

Table 5.35: Percentage of people with dementia in nursing, residential and dual registered homes

People with dementia	Nursing		Residential		Dual		Total	
	n	%	n	%	n	%	n	%
Under 60%	19	25	70	52	38	51	127	44
Over 60%	57	75	65	48	37	49	160	56
Total	76	100	136	100	75	100	287	100

χ^2 : p - .007

Source Question: 1: Please estimate the approximate percentage of your residents who suffer from dementia or are confused

Lower age boundary

Most homes had some lower boundary (see Table 5.36). In 70 per cent of these cases this was set at either 60 or 65 years. A slightly higher percentage of non-EMI homes compared with EMI homes had a lower age boundary.

Table 5.36: Homes with and without a lower age boundary for people with dementia

Age boundary	EMI		Non-EMI		Total	
	n	%	n	%	n	%
No	22	14	12	10	34	12
Yes	134	86	108	90	242	88
Total	156	100	120	100	276	100

χ^2 : p = ns

Source Question: 2: Please indicate the lower age boundary for people with dementia being accepted into your facility

When two factors were brought together to form a composite measure of a service targeted for people with dementia the results demonstrated that just over half of the homes (52 per cent) in the sample were targeted in this way. Homes were allocated one point if they cared for over 60 per cent people with dementia and a further point if they were either an EMI home or, if they were not, they had designated beds for people with dementia. As one would expect, EMI homes scored significantly higher than non-EMI homes (Table 5.37). There was also a statistically significant difference between nursing, residential and dual registered homes, with nursing homes having the highest mean score, suggesting that these homes are more targeted than either residential or dual registered homes in relation to people with dementia (Table 5.38)

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Table 5.37: Homes with service targeted at people with dementia

Score (maximum =2)	EMI (n=162)		Non-EMI (n=125)		Total (n=287)	
	n	%	n	%	n	%
0			30	24	30	10
1	38	23	71	57	109	38
2	124	77	24	19	148	52
Targeting composite Mean (SD)]	1.8 (.42)		0.9 (.66)		1.4 (.67)	

KW: p =<.00

Source Questions: 1: Please estimate the approximate percentage of your residents who suffer from dementia or are confused; 5: Which of the following best describes your facility?; 6: For homes not designated as a specialist EMI establishment, how many of your places are specifically designated for people with dementia?

Table 5.38: Homes with service targeted at people with dementia – nursing, dual registered and residential

Score (maximum = 2)	Nursing		Residential		Dual registered		Total	
	n	%	n	%	n	%	n	%
0	4	5	20	15	6	8	30	10
1	18	24	57	42	34	45	109	38
2	54	71	59	43	35	47	148	52
Targeting composite [Mean (SD)]	1.7 (.58)		1.3 (.71)		1.4 (.63)		1.4 (.67)	

KW: p =<.00

Source Questions: 1: Please estimate the approximate percentage of your residents who suffer from dementia or are confused; 5: Which of the following best describes your facility?; 6: For homes not designated as a specialist EMI establishment, how many of your places are specifically designated for people with dementia?

5.4.2 Equity of access to specialist input

Whereas service targeting assesses to whom the service was offered, access to specialist input, measures the extent to which those within the service can gain access to outside expertise. The variable used to measure this quality is the same as the one measuring integration (see Tables 5.13-5.16 above). It showed that non-EMI homes had a higher percentage of specialists visiting regularly than did EMI homes. However, the most frequently cited visitor to these homes was the general practitioner rather than a dementia specialist. Community psychiatric nurses were reported as being regular visitors by 27 per cent of homes and old age psychiatrists by 22 per cent, compared with 77 per cent who reported the general practitioner. The differences between home types were not significant. In terms of contact with specialist services, 45 per cent of homes reported that they had contact with their local Alzheimer's society. This was more common among EMI homes (58 per cent) than among non-EMI homes (29 per cent) (χ^2: p = .018).

5.4.3 Independence: Good practice and building design

Aspects of practice that encouraged independence and choice were divided into two distinct areas. The first related to care practice and the second to building design. There is of course some overlap between the two areas, for example, it is likely to be easier to carry out practices that encourage independence if the home is built or adapted to this purpose.

Care practice

Six measures were considered which encouraged independence and choice. These are listed in Table 5.39 below along with the number of homes who responded positively to these questions. No differences were found between home types on the individual items or the composite score of six items. Seventy-eight per cent (225) of all homes said that all of the six practices listed took place in their home. The mean figure was 5.8. Twenty-one per cent of homes scored five out of six of the specified care practices.

Table 5.39: Care practice which encourages independence and choice

Care practice	n	%
Residents can take part in everyday activities which were part of persons lifestyle prior to admission	246	89
Possible to bring own personal belongings	287	100
Possible to bring own furniture	278	97
Residents go to rooms in the day time	277	97
Residents can have meals (other than breakfast) in their own room	282	99
Residents can have visitors at any time	287	100
Composite (max=6) [mean (SD)]	5.8(.443)	

Source Questions: 41: Are people with dementia offered the opportunity to take part in everyday activities which were part of the person's lifestyle prior to admission?; 15: Is it possible for residents to bring their own personal belongings/their own furniture?; 16: Are residents encouraged to go to their bedrooms in the day time if they wish?; 17: Can residents have their meals (other than breakfast) in their rooms?; 18: Can residents have visitors at any time?

Building design

Respondents were asked whether their building had any special design features for people with dementia and were given a list of nine possibilities (specially designed garden, enclosed secure outside space, Snoezelen rooms, reminiscence room, name plaques on residents rooms, uniquely personalised doors, signposting, uniquely personalised bedroom décor, carpet zoning). Seven features have been analysed in relation to encouraging independence, choice and individuality. Table 5.40 below shows the results of this analysis for all homes and also broken down by EMI home and non-EMI homes. It can be seen that a greater percentage of EMI homes have several of these features. Sixty-eight per cent of all homes said that they have name plaques on resident's rooms. EMI and non-EMI homes scored equally on this factor. Seventy-seven per cent of all homes said that they had an enclosed and secure outside space. This was the case in 85 per cent of EMI homes and 67 per cent of non-EMI homes. The largest differences between the EMI and non-EMI homes were in relation to personalised bedroom décor and signposting or aids to visual access. In both cases there was a 15 per cent difference between them with EMI homes scoring more highly. When combined to form a composite variable measuring factors in building design aimed at encouraging independence, the mean score out of a maximum of seven was 2.5 for non-EMI homes, just over three for EMI homes and just under three for all homes.

Table 5.40: Building design: promotion of independence and choice

Feature	EMI		Non-EMI		Total		p value
	n	%	n	%	n	%	
Specially designed garden	64	39	47	38	111	39	ns
Enclosed secure outside space	138	85	84	67	222	77	<.001
Name plaques on residents rooms	109	67	86	69	195	68	ns
Uniquely personalised doors (e.g. photographs)	39	24	17	14	56	19	.03
Signposting or aids to visual access	70	43	35	28	105	37	<.01
Uniquely personalised bedroom décor	81	50	44	35	125	44	<.01
Carpet zoning and guidance	13	8	6	5	19	7	ns
Building design to encourage Independence Composite [mean (SD)]	3.2 (1.4)		2.5(1.0)		2.9(1.4)		<.001

Source Question: 7: Does your home have any of the following special design features for people with dementia?

When these two factors – care practice and building design features – are combined the difference between home types is reduced although there is still a significant difference. Out of a maximum score of thirteen the mean score for EMI homes is 9 and for non-EMI homes 8 (Table 5.41).

Table 5.41: Independence encouraged by good practice and building design

Home Type	Mean	SD
EMI (162)	8.9	1.49
Non-EMI (125)	8.3	1.54
Total (287)	8.7	1.54
P value	<.001	

Source Questions: 7: Does your home have any of the following special design features for people with dementia?; 41: Are people with dementia offered the opportunity to take part in everyday activities which were part of the person’s lifestyle prior to admission?; 15: Is it possible for residents to bring their own personal belongings/their own furniture?; 16: Are residents encouraged to go to their bedrooms in the day time if they wish?; 17: Can residents have their meals (other than breakfast) in their rooms?; 18: Can residents have visitors at any time?

5.5 Service quality

5.5.1 Privacy

Three indicators of the level of privacy afforded to residents in a home were measured: the proportion of shared rooms, the proportion of en-suite bathrooms and whether or not residents and visitors had a designated space, other than bedrooms, to be together without disturbing others. Table 5.42 shows the results of this analysis for all homes and for EMI and non-EMI homes. Twelve per cent of all homes had over 20 per cent shared rooms. Thirty-five per cent of all homes had over 30 per cent en-suite facilities in rooms and 80 per cent of all homes had a ‘quiet room’. The only statistically significant difference between home types related to shared rooms, with non-EMI homes having less of these than EMI homes. When the three privacy measures were combined to form a composite variable for privacy the mean scores were similar for all home types measured. The mean for all homes was 2 out of a maximum of three.

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Table 5.42: Measures of privacy in all homes

Measure	EMI 162		Non-EMI 125		Total 287		p value
	n	%	n	%	n	%	
Less than 20 per cent shared rooms	136	84	118	94	255	88	.006
More than 30 per cent en- suite	52	32	47	38	100	35	ns
Existence of quiet room	131	81	98	79	230	80	ns
Privacy composite (max=3) [mean (SD)]	1.98(.77)		2.1(.67)		2.0 (.73)		ns

Source Questions: 13: How many shared rooms are there?; 14: How many rooms is en-suite?; 19: With the exception of resident's bedrooms, are there places for residents and visitors to be together without disturbing other residents? (e.g. quiet room, visitors room)

5.5.2 Person focused care/Individuality

Nine variables were combined in order to produce a measure of person focused care or individuality. These are detailed below (Table 5.43) along with the composite mean score for all homes, and also EMI and non-EMI homes. Overall, homes scored almost seven out of a maximum of nine on this measure. When EMI and non-EMI homes are compared, only two of the individual measures were of statistical significance: personalised bedroom doors and decor, whilst a third, the production of an individual care plan for each resident, almost reached significance. The composite mean score shows a significant difference between EMI and non-EMI homes with EMI homes scoring more highly on this measure.

Table 5.43: Practices indicating person focused care

Care practice	EMI (n=162)		Non-EMI (n=125)		Total (n=287)		p value
	n	%	n	%	n	%	
Possible to bring personal belongings	162	100	125	100	287	100	ns
Possible to bring own furniture	157	97	121	97	278	97	ns
Assessment after 3 months	132	81	92	74	224	78	ns
Care plan always	150	93	107	86	257	89.	.055
Key worker	127	78	101	81	228	79	ns
Residents encouraged to take part in everyday activities	140	86	106	85	246	86	ns
Additional help for sensory impairment	63	39	47	38	110	38	ns
Personalised bedroom doors	39	24	17	14	56	19	.026
Personalised bedroom decor	81	50	44	35	125	44	.012
Individuality composite [mean (SD)]	6.5 (1.3)		6.1 (1.4)		6.3 (1.3)		.011

Source Questions: 7: Does your building have uniquely personalised doors/uniquely personalised bedroom décor?; 15: Is it possible for residents to bring their own furniture/personal belongings?; 28: Do you complete an assessment form on people with dementia in the first 3 months after admission?; 30: Do you make a care plan for each service user as a result of an assessment?; 40: Do you have a key worker system in operation?; 41: Are people with dementia offered the opportunity to take part in everyday activities?; 46: For residents with dementia do you provide any additional specialist help with sensory impairments?

No differences were found in relation to this composite when nursing, residential and dual registered homes were compared. On the individual items that make up the composite the only statistically significant finding was in relation to key workers: residential homes having significantly more of these than either nursing or dual

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registered homes (anova: p = .024). This is considered separately below (Table 5.50).

5.5.3 Training

Respondents were asked which staff groups, if any, had received specialist training in dementia care and the form this had taken. Overall, 32 per cent of homes had no care staff that had attended an external dementia care training course (Table 5.44) whilst the qualified nursing care staff of 22 per cent of homes had had no specialist dementia care training of any sort (Table 5.45). Table 5.45 shows the type of training that different staff groups had received. Nursing staff had had more external training than had non-nursing care staff. Non-nursing care staff, on the other hand, had received more induction and informal training in dementia care. The only statistically significant difference found between home types related to registered mental nurses, more of whom had attended an external training course in EMI homes than in non-EM-homes (Table 5.46).

Table 5.44: Homes with some care staff in receipt of external dementia care training

External training	Total homes	
	n	%
No staff	93	32
One or more staff groups	195	68
Total	287	100

Source Question: 27: Please tell us which groups of staff have received training in dementia care and what form this takes?

Table 5.45: Nursing and non-nursing staff training in dementia care in all homes

Type of training	Nursing staff		Non-nursing care staff		Total staff	
	n	%	n	%	n	%
No dementia care training	62	22	102	16	164	18
General Induction course	103	37	317	50	420	46
External Training course	134	49	247	39	381	42
Informal training course	98	36	383	61	481	53

Source Question: 27: Please tell us which groups of staff have received specialist training in dementia care and what form this takes?

Table 5.46: Staff attending external dementia care training course

Staff group	EMI		Non-EMI		Total		p value
	n	%	n	%	n	%	
RGN	(n=89)		(n=53)		(n=142)		ns
	42	47	24	45	66	46	
RMN	(n=93)		(n=39)		(n=132)		.009
	49	53	21	54	70	53	
Senior care staff	(n=131)		(n=107)		(n=248)		ns
	65	50	54	50	119	48	
Care/nursing assistants	(n=153)		(n=122)		(n=275)		ns
	59	39	53	43	112	41	
Activity staff	(n=67)		(n=49)		(n=116)		ns
	12	18	13	27	25	22	

Source Question: 27: Please tell us which groups of staff have received training in dementia care and what form this takes?

5.5.4 Management and care worker good practice

Staff supervision and appraisals

Respondents were questioned about the extent of staff supervision and annual appraisal arrangements in their homes. Table 5.47 shows that 62 per cent of homes overall stated that all their staff were regularly supervised and appraised and that although there were differences between home types, these were not statistically significant. Table 5.48 shows a breakdown of supervision and appraisal by nursing and non-nursing care staff. It illustrates that significantly more EMI homes offered regular supervision and appraisal to their nursing care staff than did non-EMI homes. Differences between home types for non-nursing care staff were not statistically significant.

Table 5.47: Proportion of staff in receipt of regular supervision and appraisal

Arrangements for all staff	EMI		Non-EMI		Total		p value
	n	%	n	%	n	%	
Appraisal	107	66	70	56	177	62	ns
Supervision	95	59	84	67	179	62	ns
Total	162	100	125	100	287	100	

Source Question: 26: Which staff receive regular one to one supervision/have their performance formally reviewed?

Table 5.48: Proportion of nursing and other care staff in receipt of regular supervision and appraisal

Staff group appraisal and supervision	EMI		Non-EMI		Total		p value
	N	%	N	%	N	%	
All qualified nursing staff appraised	67	41	33	26	100	35	.008
All other care staff appraised	108	67	75	60	183	64	ns
All qualified nursing staff supervised	56	35	24	19	80	28	.004
All other care staff supervised	111	68	94	75	205	71	ns
Total	162	100	125	100	287	100	

Source Question: 26: Which staff receive regular one to one supervision/have their performance formally reviewed?

Seven management practices were considered that were regarded as measures influencing care worker good practice: supervision and training practices; the operation of a key worker system; and the involvement of care workers in service user's reviews. These variables are summarised below in Table 5.49 alongside the composite mean. The mean score was 4.7 for all homes from a maximum possible of seven. No differences were found between EMI and non-EMI homes.

Table 5.49: Management practices influencing care worker good practice

Good practice	EMI		Non-EMI		Total		p value
	n	%	n	%	n	%	
General induction course on dementia care	87	54	64	51	152	53	ns
External dementia care training course	59	36	53	42	112	39	ns
Informal training with senior members of staff in dementia care	114	70	81	65	196	68	ns
Regular supervision	122	75	104	83	227	79	ns
Annual appraisal	114	70	73	58	188	65	ns
Routinely attend reviews	132	82	107	86	240	83	ns
Key worker system in operation	127	80	101	81	229	80	ns
Good practice composite [mean (SD)]	4.7(1.50)		4.7(1.43)		4.7(1.47)		ns

Source Question: 26: Which staff receive regular one to one supervision/have their performance formally reviewed?; 27: Please tell us which groups of staff have received specialist training in dementia care and what form this takes; 31: Do care/nursing assistants attend care planning meetings?; 40: Do you have a key worker system in operation?

Key worker systems and practices

Respondents were asked whether they operated a key worker or named nurse system within their home. As can be seen in the summary table above, 229 homes, (80 per cent) operated this type of system. Statistically significantly more key workers were found in nursing homes (88 per cent) than in residential (81 per cent) or dual registered homes (71 per cent) (Table 5.50). The difference between EMI and non-EMI homes was only one per cent. A significantly higher proportion of local authority (95 per cent) and voluntary sector homes (93 per cent) were found to operate a key worker system than private sector homes (77 per cent).

An open question was asked to elicit information about the main tasks of key workers within homes. These were post-coded into eight main areas: the promotion of psychological well-being; informal recreation; household maintenance; staff interaction; family interaction; advocacy; physical care; and 'anything and everything'. As indicated in Tables 5.51 and 5.52, 27 per cent of all homes with key worker systems in operation stated that their key workers were involved in the promotion of psychological wellbeing. The only finding of statistical significance related to physical care provided by key workers, which was found to be greater in residential homes compared with nursing and dual registered ones. This activity almost reached significance for EMI and non-EMI homes, with the latter providing more (19%) compared with EMI homes (10%).

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Table 5.50: Homes operating key worker system by residential, dual registered and nursing home types

Key worker	Nursing		Residential		Dual		Total	
	n	%	n	%	n	%	n	%
No	9	12	25	29	22	29	56	20
Yes	67	88	108	81	53	71	228	80
Total	76	100	133	100	75	100	284	100

χ^2 : p = .024

Source Question: 40: Do you have a key worker system in operation?

Table 5.51: Key worker categories of activity by EMI and non-EMI homes

Categories of activity	EMI (n =127)		Non-EMI (n =101)		Total (n =228)		p value
	n	%	n	%	n	%	
Physical care	13	10	19	10	32	14	.064
Promoting psychological welfare	30	24	32	32	62	27	ns
Informal recreation	2	2	4	4	6	3	ns
Household maintenance	14	11	14	14	28	12	ns
Staff interaction	3	2	5	5	8	4	ns
Non specific	32	25	27	27	59	26	ns
Family interaction	15	12	21	36	16	1	.065
Advocacy	4	3	1	1	5	2	ns

Source Question: 40: Do you have a key worker system in operation?

Table 5.52: Key worker categories of activity by residential, nursing and dual registered homes

Categories of activity	Nursing (n =67)		Residential (n =108)		Dual (n =53)		Total (n =228)		p value
	n	%	n	%	n	%	n	%	
Physical care	2	3	23	21	7	13	32	14	.003
Promoting psychological welfare	19	28	27	25	16	39	62	27	ns
Informal recreation	0	0	5	5	1	2	6	3	ns
Household maintenance	6	9	18	17	4	7	28	12	ns
Staff interaction	1	1	5	5	2	4	8	4	ns
Non specific	14	21	53	31	12	23	59	26	ns
Family interaction	10	15	14	13	12	23	36	16	ns
Advocacy	1	1	4	4	0	0	5	2	ns

Source Question: 40: Do you have a key worker system in operation?

5.5.5 Carer involvement and support

A number of questions were asked in order to identify the nature of involvement and support offered to carers. The results can be seen in Table 5.53. Forty-seven per cent of homes stated that carer's needs were identified on their assessment documentation whilst 31 per cent stated that they had formal arrangements for providing support for carers. Seventy-three per cent of homes reported routinely inviting carers to reviews with 39 per cent stating that carers often attended. Carers were more likely to be invited to reviews in non-EMI homes. Arrangements for providing carer support were however more common in EMI homes. When the six indicators were combined to form a composite measure of carer involvement and

support, the mean scores were 2.2 for all homes, 2.1 for EMI homes and 2.3 for non-EMI homes.

Table 5.53: Carer involvement and support

Type of support	EMI		Non-EMI		Total		p value
	n	%	n	%	n	%	
Carer needs identified on assessment documents	71	44	64	51	135	47	ns
Carers routinely invited to reviews	107	68	96	79	203	73	.031
Formal arrangements/resources for involving/sharing care with relatives	42	28	42	34	84	31	ns
Formal arrangements/resources for providing support for relatives/ friends of people with dementia	43	29	22	18	65	24	.042
Carers often attend reviews	59	36	52	42	111	39	ns
Care plan routinely sent to relatives.	15	9	9	7	24	8	ns
Carer involvement and support composite [mean (SD)]	2.1(1.45)		2.3 (1.21)		2.2 (1.35)		ns

Source Questions: 29: Does your assessment from specify carers needs?; 32:Do you send copies of care plans to relatives?; 34: Do you routinely invite relatives/carers to reviews?; 35: Do relatives/carers attend reviews in your home?; 36: do you have formal arrangements or resources for providing support for close relatives/friends of residents with dementia?

5.5.6 Respite care

Respondents were asked whether they offered respite care placements, and, if so, whether these were subject to availability or were specifically designated beds. There were a total of 405 respite places, subject to availability, representing between four per cent and five per cent of the total beds. Two hundred and forty-five homes, 85 per cent, said that they offered respite places. Table 5.54 shows a breakdown of these figures for EMI and non-EMI homes. Significantly more non-EMI homes offered respite beds than EMI homes. Only 158 homes (55 per cent) provided details of the number of beds they had available. Sixty-two per cent of homes had between one and two places and another 19 per cent had between three and six respite beds. The difference between EMI and non-EMI homes was not significant.

Only 39 homes (16 per cent of the total number of homes offering respite places) had specifically designated respite beds. Of these, 65 per cent had between one and two places with another 19 per cent having between three and ten places. The mean number of specifically designated respite beds was three with a total of 130, representing between one and two per cent of total places across all homes. The difference between EMI and non-EMI homes was not significant.

Table 5.54: EMI and non-EMI homes offering respite places

Respite beds	EMI		Non-EMI		Total	
	n	%	n	%	n	%
Homes available	131	81	113	90	245	85
Total	162	100	125	100	287	100

χ^2: p = .039.

Source Question: 10*:* Do you offer respite places?

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5.5.7 *Quality assurance*

The most common accreditation scheme was the 'Investors in People' programme. Thirty–two per cent of all homes were currently accredited with this scheme. Table A3 in Appendix 2 details the numbers accredited with different programmes by home types. Forty-five per cent of all homes were currently externally accredited by one or more quality assurance programme. There was no difference between EMI and non-EMI home types. A slightly higher percentage of nursing homes were accredited than the other home types, although this was not significant. The figures are shown in Table 5.55 and Table 5.56.

There was a slight difference between local authority types in relation to quality assurance with 53 per cent of homes in unitary authorities being accredited compared with 44 per cent in metropolitan authorities and 45 per cent in county authorities.

Table 5.55: External accreditation by one or more quality assurance programmes - EMI and non-EMI homes

Accreditation	EMI		Non-EMI		Total	
	n	%	n	%	n	%
No	89	55	67	54	156	55
Yes	73	45	58	46	131	45
Total	162	100	125	100	287	100

χ^2 : p = ns

Source Question: 24: Is your home currently externally accredited by one or more quality assurance programme?

Table 5.56: External accreditation by one or more quality assurance programmes - Residential, dual registered and nursing homes

Accreditation	Nursing		Residential		Dual		Total	
	n	%	n	%	n	%	n	%
No	36	47	72	53	48	64	156	55
Yes	40	53	64	47	27	36	131	45
Total	76	100	136	100	75	100	287	100

χ^2 : p = ns

Source Question: 24: Is your home currently externally accredited by one or more quality assurance programme?

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6 CONCLUSION AND DISCUSSION

This research has examined the scope and nature of care homes that provide services for people with dementia in the North West of England. A postal questionnaire has been used to gather a large amount of data in order to produce a map of these services. As such it represents the first study of this kind. There were approximately 69,000 care home places for older people in the North West of England at the end of the 1990's (Laing and Buisson, 1999). Our sample of 287 homes with 9,256 beds represents 13 per cent of this figure. They represent homes that provided a service, either exclusively for, or that dedicated themselves in part to, older people with dementia. The high response rate achieved (73 per cent) gives credibility to the claim that the results are representative of the whole of the North West of England.

The 22 local authorities in the North West of England represent 19 per cent of England's local authorities outside London and not including District Councils (which do not provide social care services) (Local Government Association, 2001). The population aged over 65 years living in the North West of England represents 16 per cent of the population of England aged over 65 (Census, 2001). The North West of England shares the age group percentage breakdown with England as a whole, with 28 per cent aged between 65 and 69, 25 per cent between 70 and 74, 21 per cent between 75 and 79, 14 per cent between 80 and 84, 8 per cent between 85 and 90 and 4 per cent being over the age of 90.

Figures for older people (75 years and over) residing in long-term care facilities (residential and nursing homes) suggest, however, that the North West of England is not typical of the whole of England, having a higher mean compared with the country as a whole. The mean figure for England stood at 56 per 1000 (95 per cent CI = 52-60) compared to a mean figure of 74 per 1000 for North West England. The difference between England and the North West of the country was much greater for nursing home placements than for residential homes with the average for residential care in England standing at 19 per 1000 (95 per cent CI = 18-20) compared with 22 per 1000 for North West England. For nursing homes the England mean figure was 36 (95 per cent CI = 33-40) compared with 51 for North West England (Department of Health, 2002).

The 22 councils with social services responsibilities (CSSRs) in the North West of England represent 19 per cent of England's local authorities outside London (LGA, 2003), and represent about 15 per cent of the CSSRs in England.

The standards measured are of importance to the whole country, whilst the greater proportion of the population over 75 years living in long-term care in the North West of England, means that the data on quality standards measured and reported here is of even greater importance to policy makers, planners and practitioners in this region. Although there are undoubtedly some gaps in the information and some limitations in the methodology – a reliance on home managers for data and focus only on the more quantifiable – it presents a more than useful starting point for further research. Overall the results demonstrate that care homes are struggling to meet many of the new standards set by the National Care Standards Commission

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and the National Service Framework for Older People. The key findings of the research are discussed below under the following headings:

- Variations between local authorities
- Quality measures in service provision
- Specialist and non-specialist care

A final brief section considers these findings in the context of current policy initiatives requiring the development of specialist provision for older people with dementia within the care home sector.

6.1 Variations between local authorities

The North West of England has been considered as a whole for the majority of this study. The region was, however, broken down into local authority areas and local authority types for a few key variables: occupancy levels, home types, and EMI places.

6.1.1 Occupancy and funding issues

There was an overall vacancy rate across the North West of England of 11 per cent. This was slightly lower than that recorded by Laing and Buisson for 1999/2000 who state that occupancy levels across the country were then running at the mid 80 per cent range (Lang and Buisson, 1999). Metropolitan boroughs had a slightly higher rate than either county or new unitary authorities.

Seventy four per cent of residents were funded by local authority social services departments. These figures were close to those found by other researchers (Netten et al., 1998, 2001; Laing and Buisson, 1999). Given that these residents often pay less for the same service than privately funded residents (Laing, 2002) this result, coupled with the vacancy rate, suggests that there might be funding shortfalls for homes in the North West of England. Netten and colleagues (2002) demonstrated that home closures across the country were more likely to be the result of under-funding than of poor quality care. Funding shortfalls, however, are likely to impact on the quality of the service offered as home owners face new challenges of meeting building and service standards.

6.1.2 Home types

In relation to home types it was found that metropolitan boroughs are better served by EMI homes than other authority types, suggesting that city dwellers have greater access to more ‘specialist’ care than their more rural and small town neighbours. However, the debate over whether EMI homes offered a ‘better’ service to people with dementia was not resolved by this study. This is discussed further below.

6.1.3 EMI places

Measuring the number of places available to and currently occupied by people with dementia proved to be a complex task and our figures remain only estimates. One of the difficulties was an unknown level of under or over-reporting by respondents. Another was that ‘EMI’ homes are not inhabited only by people with dementia. There

will be a proportion of other residents with long-term mental health problems. Our figures however assume that 100 per cent of places in EMI homes are at least available to if not currently occupied by people with dementia.

Given these qualifications, our findings show that the availability of EMI places in all home types varied greatly across the North West of England. As a whole, the rate per 1000 for the region was between 6.7 (recorded) and 8.8 (estimated) but this mean masked a range of between 1.1 and 23.7. Considering these figures against the overall estimated dementia prevalence rate for those over 65 years of 9.3 per cent (Hofman et al., 1991) or even at the basis of a more conservative figure of around 5 per cent raises questions about the distribution and future requirements for specialist care home places for dementia in the region. Given that approximately one third of older people with dementia enter residential care (Nolan and Grant 1992; Kavanagh et al., 1993), key questions include the future bed requirements for people with dementia and also the proportion of beds which should be classified as specialist.

6.2 Quality measures in service provision

This section summarises the variation found within the whole sample on key measures of quality used in this study. This is followed by a section that compares the findings for non-specialist homes with a proportion of specifically designated beds for older people with dementia and homes specialising in the care of the elderly mentally infirm.

6.2.1 Structural measures

Service integration

It was noted by the Audit Commission (2000) that one third of residents in EMI homes had been transferred from other homes, suggesting that the latter were unable to cope with these people's care needs. They noted the need to improve support to this type of care home in order to reduce this practice. Recent work by Jacobs and Glendinning into the accessibility of community services to care home residents (2001) found that only five per cent of homes sampled had access to a psycho-geriatrician and 46 per cent to the services of physiotherapists, occupational therapists and speech therapists with the majority able to access a specialist nurse. This research measured the number of outside specialists visiting regularly as well as who they were and the most frequently cited specialist dementia care agency with which they were in regular contact. The results are summarised in Box 6.1.

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Box 6.1: Key findings on measures of integration

- Mean number of regularly visiting professionals = 3
- Most frequently cited professional visitors to home:
  77% general practitioner
  46% community nurse
  37% care manager
  27% community psychiatric nurse
  22% cent old age psychiatrist
- The Alzheimer's society was the most frequently sited specialist dementia care agency with which homes had contact (49%)

Despite the different emphasis, the research findings of this study are in line with Jacobs and Glendinning in suggesting a limited level of support and a largely non-specialist one. Whilst integration between health and social care has become a widely accepted strategy to ensure that provision meets the range and extent of need (Mountain and Godfrey, 1995; Van Raak, et al., 2003), very few services were integrated according to our range of measures.

Management and staff qualifications

The National Minimum Standards for Care Homes for Older People state that by 2005 all registered home managers are required to have a NVQ level 4 in management and care or an equivalent qualification. Where nursing care is provided the manager must have a nursing qualification and a relevant management qualification (Department of Health, 2001a). The findings of this research in relation to managers' qualifications are detailed in Box 6.2 below. Three-quarters of the homes in this sample fell short of the required management qualification for 2005. A qualified nurse manager was not found in only 3 per cent of homes to which this requirement applied.

Box 6.2: Managers' qualifications

97% nursing homes had a qualified nurse manager
62% all homes had a qualified nurse manager
26% managers had an NVQ level 4
20% homes had manager with neither a nursing qualification or an NVQ4
7% homes had a manager with no relevant qualification, i.e. not even NVQ level 2
5% managers had an NVQ level 2 or 3

National minimum standards require that at least 50 per cent of care staff must have obtained a NVQ level 2 by 2005 (Department of Health, 2001a). The mean percentage of qualified nursing care staff to total care staff in all homes in this sample was 12. Forty-eight per cent of all homes employed no qualified nursing care staff. Unfortunately this research did not gather data on the qualifications of non-nursing care staff. However, our data suggests that for every one qualified nurse there are seven 'unqualified' or at least non-nurse staff for every 10 occupied places (Box 6.3). This ratio will fail to take account of shift patterns, holidays and sickness. The National Care Standards Commission do not stipulate a definite number of staff to be on duty on a day or night shift. Rather, they provide a formula for managers to

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use, constructed by the Residential Forum for calculating appropriate staff numbers (Department of Health 2001a; Clough, 2002). They state that for every 10 high dependency residents there should be a minimum of seven full-time equivalent care staff employed. The numbers indicated by this research suggest that homes in the North West of England may have a staff complement that meets this minimum.

Box 6.3: Ratios of staff to residents

- 1 qualified nurse employed for every 10 residents
- 7 non-nursing care staff employed for every 10 residents
- Figures need adjusting downwards to take account of shifts and holidays
- Staff numbers meet minimum requirement set by Residential Forum

6.2.2 Service process measures

Assessment practices

Assessment is widely recognised as pivotal in the practice of health and social care (Challis et al., 1989; Challis et al., 1996; Stewart et al., 1999). It is also recognised as an ongoing process rather than a one off practice and it is expected that care homes will take part in this process (Department of Health, 2001b). For the 26 per cent of their residents who are privately funded, care homes are expected to carry out a full needs assessment prior to admission (unless there has been care management involvement and therefore assessment). There is no expectation that they carry out this level of assessment prior to admission on publicly funded residents. The National Service Framework for Older People stresses the need for services to work together to reduce duplication (Department of Health 2001b). Clearly it is expected that the assessment process should continue once a service user has entered residential care.

Seventy-eight per cent of respondents stated that they completed an assessment on a new resident with dementia within three months of admission to their home. How these assessments link up with those of care managers prior to admission would require further investigation and could demonstrate the extent of continuity of care. Equally it could uncover duplication and confusion of roles and responsibilities. Ninety per cent of the 225 homes that stated that they carried out assessments within three months of admission also stated that they produced a care plan as a result of this. Only a quarter of the sample stated that they held reviews of residents' needs on a three monthly or more frequent basis. These figures suggest that the majority of homes start off with good intentions in their assessment and care planning practices but that they find it difficult to maintain in the longer run with the result that reviews become less frequent. Nevertheless, the National Care Standards stipulate that care plans must be reviewed on a monthly basis, and it has been noted by Challis and colleagues (1998) that the linkage between assessment, care planning and periodic review is good practice. However, it appears from these results that many care homes need to improve their practice in relation to this.

A consideration of the content of assessments revealed that many homes gathered some information but few gathered all the information outlined in the research questionnaire. The weakest area of the majority of assessments was in the social-

environmental domain that comprised aspects of both an individual's cultural and recreational history and preferences. See Box 6.4 for more details.

Box 6.4: Extent to which assessment documents covered different assessment domains in full

58% Functional domain
48% Clinical domain
45% Cognitive domain
2% Social/environmental domain

This suggests that care staff required more training in assessment practices to raise the profile of the importance of collecting this type of information on service users, and to highlight the impact of not doing so on the quality of care offered. If someone with dementia is not recognised as an individual at the assessment stage, in the first few months of their stay in a care home, they are unlikely to be treated as an individual in relation to the service they receive. A cornerstone of the National Service Framework for Older People (Department of Health, 2001a) is the need to ensure that services meet individual need. In the care of those with dementia it would appear that there is still some way to go to fulfil this policy directive in terms of assessment practice.

Rehabilitation and stimulating activities

Rehabilitation is not a concept often linked with people with dementia, who are often seen as needing only to be made comfortable. Yet a number of studies have shown that involvement in stimulating activities can have a positive influence on life quality (Martichuski et al., 1996, Morgan and Stewart, 1997). Spector and colleagues (2000) suggest that appropriate therapies and support can have a positive impact on behaviour and cognition. It is also known that dementia sufferers often have other medical problems that can sometimes be overlooked, and the person's disorientation may be attributed entirely to dementia, when it might be that they simply require a new hearing aid or pair of glasses. It was with this in mind that measures relating to this: reality orientation, reminiscence, visiting outside professionals, help with sensory impairment, were considered (Box 6.5). Individual item scores were largely below 50 per cent. The composite of the nine features resulted in a mean score of only 2.6. This result suggests that homes are not yet focusing on this aspect of care to any great extent. This supports previous findings of low levels of active engagement in stimulating activities and therapies for people with dementia in residential care (Ballard et al., 2001)

The national minimum standards state that care services for older people should respect individuality and that activities offered by homes therefore need to be flexible and varied. The lists of activities offered by homes in this research demonstrated a limited range available and also suggested that those offered represented activities largely associated with stereotypical views of older people's leisure rather than activities targeted at individuals with a range of interests.

Box 6.5: Rehabilitation practices

89% Residents encouraged to take part in everyday activities 77% Activity and exercise 56% 3 or more different professionals visit regularly 49% Additional help for sensory impairment 41% Member of staff to run reminiscence activities 39% Specially designed garden 22% Member of staff to run reality orientation activities 17% Member of staff to run other activities 12% Snoezelen room 11% Reminiscence room

6.2.3 Service content measures

Access for ethnic minority people with dementia

The NHS plan (Department of Health, 2000a) and the National Service Framework for Older People (Department of Health, 2001b) both put access to services for all the diverse populations of Britain at the centre of their aspirations. The findings of this research suggested some cause for concern in this area. Ethnic minorities currently make up four per cent (275,700) of the population of the North West of England (6,894,000). Only 2.7 per cent of this population (excluding Irish and including 'other non-whites') however is over the age of sixty-five years (Census UK, 2001), compared with 19 per cent of the white population across Britain as a whole (Patel et al., 1998). The occupancy levels of ethnic minority elders made up just one per cent of care home places in this study, suggesting that ethnic minority elders are not accessing care home places in numbers comparative to their representation in the general population (Appendix 2 Table A2). These findings mirror those of previous research into access to care services for ethnic minority communities (Patel and Mirza, 1998, Department of Health, 1998a). The research was not able to accurately gather information on how many of these residents had dementia.

In relation to specialist facilities for ethnic minority residents, and information gathering on cultural traditions during the assessment process, however, the results were poor. This data was consistent with previous research findings (Department of Health, 1998a). In short, it appears from this data that ethnic minority elders are not entering residential care in the numbers one might expect, whilst the quality of care they receive may not be culturally sensitive. Little is known about the care needs of ethnic minority elders with dementia, particularly whilst resident in the community. The stigma attached to symptoms of dementia in some ethnic minority communities means that services need to work even harder with them to break down barriers to access (Mackenzie and Gallagher, 2002). The two key findings are summarised in Box 6.6.

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Box 6.6: Ethnic minority findings

Occupancy levels by ethnic minority elders do not reflect their numbers in the population of ethnic elders in the North West of England Care offered often not culturally sensitive

Targeting: Numbers of people with dementia in care homes

Recent research findings suggest that the number of people with dementia living in care homes is rising and that this is particularly the case for nursing homes (Mozley et al., 2000). Our findings would concur with this (Box 6.7). Netten (1993) suggested that the numbers of people who are confused in non-specialist care homes should not exceed one third. Our results show that over a quarter of non-specialist homes had over 60 per cent people with dementia making up their resident populations.

Box 6.7: Proportion of people with dementia in different types of homes

- Nursing homes have significantly more people with dementia than other home types
- EMI homes have significantly more people with dementia than non-EMI homes

76% EMI homes have over 60 per cent people with dementia
64% EMI homes have over 81 per cent people with dementia
55% all homes have over 60 per cent people with dementia
40% all homes have over 81 per cent people with dementia
28% non-EMI homes have over 60 per cent people with dementia
14% non-EMI homes have over 81 per cent people with dementia

Independence: Practice issues

Homes in the North West of England gave an encouraging response to questions relating to this theme and although there is likely to be an element of social desirability in the responses, the results nevertheless suggest a high level of awareness in homes of the needs of service users in this respect. These are summarised in Box 6.8. Choice, at one time a factor recognisable by its absence in care homes, appears now to be firmly on the agenda.

Box 6.8: Care practices to encourage independence and choice

100% Residents can have visitors at any time
100% Possible to bring own personal belongings
99% Residents can have meals (other than breakfast) in their own room
97% Possible to bring own furniture
97% Residents go to rooms in the day time
89% Residents participate in everyday activities which were part of persons lifestyle prior to admission

Independence: Building design features

Marshall and Cox (1998) and others (for example Calkins, 1988) have noted the importance of the physical environment in enhancing the quality of care for people with dementia. The majority of homes in this sample had taken up some of the more basic features associated with improvements in residents behaviour (Tune and Bowie, 2000) such as name plaques on people's doors and over three quarters stated that they had a secure outside space as illustrated in Box 6.9. However, less than half had uniquely personalised bedroom décor and only seven per cent had carpet zoning. Contrary to the findings of Tune and Bowie, this study found that there

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was a significant difference between EMI and non-EMI homes in relation to building features with EMI homes generally having more of these features.

Box 6.9: Building design features

77% Enclosed secure outside space
68% Name plaques on residents rooms
44% Uniquely personalised bedroom décor
39% Specially designed garden
37% Signposting or aids to visual access
19% Uniquely personalised doors
7% Carpet zoning and guidance

6.2.4 Service quality measures

Privacy

The principal findings in respect of measures of privacy are summarised in Box 6.10. The National Care Standards Commission have diluted their original requirement in relation to this standard, as a result of successful lobbying by home owners. All new builds and extensions are required to have 100 per cent single rooms and en-suite facilities, existing homes, however, do not have to change their current establishment (Department of Health, 2003). All homes are required to have 'a quiet room' meaning that 20 per cent of the homes in this sample are failing to meet this requirement.

Box 6.10: Privacy measures

80% had a 'quiet room'
35% had less than 30 per cent en-suite facilities
12% had over 20 per cent shared rooms

Staff training

The literature to date describes a workforce in care homes who are under paid, undervalued, and who lack the training and expertise required to care appropriately for people with dementia (Netten, 1993; Marshall, 2001). There have also been studies that reported positive links between training and resident well being as well as improved job satisfaction and reductions in worker stress (Grant et al., 1996; McMallion et al., 1999). As can be seen in Box 6.11, the specialist dementia training levels among the staff in the North West of England showed a significant number of staff working with people with dementia who had not received any form of specialist dementia care training (18 per cent). Less than half the care staff in the sample had received a general induction in dementia care (46 per cent), or attended an external dementia care training course (42 per cent). Just over half had attended an informal training course (53 per cent). The National Care Standards Commission states that all staff must have a general induction within six weeks and foundation training within the first six months of their appointment and that this training must equip them to work with the service user group resident in their setting (2001b). It would seem from the results of this research, as Bagley and colleagues also highlighted (2003), that these targets were not being met.

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Box 6.11: Specialist dementia care training by care staff

53% Informal training in dementia care
46% Received an induction in dementia care practice
42% Attended an external dementia care course
18% No training in dementia care

Carer support

This has been high on the government's agenda for a number of years and is clearly of vital importance to those caring for people with dementia who are often old themselves (Levin, 1997). It has been shown that carer stress is reduced by offering support facilities that involve carers in decision making about their relatives (Almberg et al., 2000).

The findings of this research suggest that this is still only happening in a limited way as illustrated in Box 6.12. There is also some indication of how difficult it can be to provide this type of support effectively. For example 73 per cent of respondents stated that they routinely invite carers to reviews yet only 39 per cent state that carers routinely attend. In the context of the earlier remarks about the numbers of reviews actually being held regularly, some care should be taken in interpreting these figures, nevertheless, issues of access are present here in a similar way as has been discussed for ethnic minority communities. Offering a service is often not enough to ensure that the service is taken up. A more pro-active approach may be needed to encourage carers to feel welcomed and valued. The key worker could play a role in developing this and yet the results of this research show that only a small percentage of key workers have any interaction with family members.

Box 6.12: Carer support

73% Routinely invite carers to reviews
31% have Formal arrangements for involving carers in their relative's care
24% have Formal arrangements for supporting carers directly

Respite care

Box 6.13 reveals that respite care was offered in the majority of homes (85 per cent) but each home offering this service provided only a small number of places. Overall this meant that the level of respite provision was low. It is difficult for homes under financial pressure to keep a bed vacant as a designated respite bed without funding. The latter therefore represented an even smaller number than those subject to availability: two per cent of total places compared with five per cent for those subject to availability. Although there is some disagreement as to the use carers make of respite services as either a stepping stone to long term care for their relative (Levin et al., 1989; Zarit et al., 1999) or as one of a range of services that help them to continue their caring role (Pearson et al., 1988), respite provision is nevertheless recognised as an important service for them (Audit Commission, 2000). The very low levels of provision available in the North West of England would therefore suggest a real gap in provision for people with dementia and their carers.

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Box 6.13: Respite care offered

- 85% homes offered Respite care available in homes
- Mean number of respite beds subject to availability -4
- 16% had Specially designated respite beds
- Mean number of specially designated respite beds -3

6.3 Specialist versus non-specialist care: Comparing EMI and non-EMI homes

Throughout the report differences between EMI homes and non-EMI homes have been identified. It would be reasonable to expect that homes that were registered or described themselves as EMI would be more likely to offer a 'specialist' and therefore better service to people with dementia than the non-EMI homes. This hypothesis is unpacked below with the evidence summarised in Box 6.14.

Box 6.14: Summary of statistically significant differences found between EMI and non-EMI homes

EMI homes had significantly more of the following:

- >60 per cent residents with dementia
- Qualified nurse managers
- Proportion of qualified nursing staff to total care staff
- All qualified nursing staff supervised
- External dementia training by RMNs
- Reality orientation activity staff employed
- Independence encouraged by building design features
- Individual activities
- Contact with local Alzheimer's society
- Formal arrangements for supporting carers

Non-EMI homes had significantly more of the following:

- Routinely inviting carers to reviews
- Three or more regularly visiting professionals
- Respite service
- Social assessment domain covered

Quality of care issues were measured and comparisons made between home types in relation to a range of care processes and practices. These included building facilities; management and staff training and qualifications; management and care worker practices; assessment and care planning practices; involvement of specialist professionals and agencies; and support offered to carers. On a number of these factors EMI homes scored more highly than non-EMI homes. For example, there were significantly more qualified nurse managers in EMI homes compared with non-EMI homes but no difference between homes in relation to managers with NVQ level 4 (all 26 per cent). There were also significantly more EMI homes with qualified nurses than non-EMI homes, and in particular more Registered Mental Nurses. In addition EMI homes offered regular supervision and appraisals to their qualified nursing staff to a greater degree than non-EMI homes and a larger percentage of Registered Mental Nurses had attended external dementia training course in EMI homes than in non-EMI homes. EMI homes were also more likely to employ staff to run reality orientation activities than non-EMI homes.

In relation to building features, EMI homes were more likely to have closed secure gardens, personalised rooms and doors, and signposting features. They were also more likely to have a Snoezelen room – though only a minority of all homes had such a facility and their benefit has been questioned by other research (Chung et al., 2002). Finally, EMI homes were more likely to be in touch with their local Alzheimer's Society than were non-EMI homes.

On the other hand, more non-EMI homes routinely invited carers to reviews, had three or more outside professionals visiting the home regularly, and offered more respite services than did EMI homes. The only significant difference found in relation to assessment practices between EMI and non-EMI homes was in favour of the latter which appeared to place greater emphasis on assessing social and environmental factors in a new resident's life.

Taking these findings together it would suggest that non-EMI homes offered a more social care and community linked model of service than EMI homes whilst the latter appeared to offer both a more clinically based service and one that was more specialised. These differences are summarised in the Box 6.15 below.

Box 6.15: Differences in care models of EMI and non-EMI homes

EMI homes demonstrated more:
- Nurses in staff group
- Staff (RMN) attend external dementia care training courses
- Staff involved in reality orientation activities
- Special design features

Non-EMI homes demonstrated more:
- Involvement of carers in care planning for relative/friend
- Respite care provision
- Involvement of outside professionals
- Emphasis on social aspects of residents lives indicated by assessment domains covered

However, these differences can be exaggerated by taking them out of the larger context. When these measures are placed among the many others outlined in the results, it can be seen that they represent only a minority of them. In many more cases, differences were statistically insignificant or simply not present. For example, although EMI homes offered more supervision than did non-EMI homes to their nursing staff, both home types offered the same level to other care staff. Whilst more non-EMI homes routinely invited carers to reviews, more EMI homes had formal arrangements or resources in place for providing support for carers.

6.4 Implications for policy and practice

Overall, this study suggests that, on the basis of the data gathered, there are some questions regarding the number, distribution and type of places in long term care homes for people with dementia in the North West of England. Although homes appear to have above minimum staffing levels set by the Residential Forum (Clough, 2002) the quality of care provided fell short on many of the measures considered by the research. There are concerns about funding, and managers' qualifications. Specialist dementia care training remains a minority experience, whilst the level of integration between care homes and other services on a day-to-day basis was limited. Following from these largely structural issues, came shortfalls in both

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process and intermediate outcomes. A significant minority of residents had only a limited degree of privacy, whilst practices that encourage rehabilitation and individuality were inadequate. Support for carers, including respite care was also insufficient. On the positive side, responses relating to practice aimed at encouraging independence were heartening, suggesting, as has been stated already, a high degree of understanding of the needs of people with dementia in relation to this area.

EMI homes fared better on many measures than non-EMI homes, including structural features such as building design, though non-EMI homes fared better than EMI homes on a few features. It was found that the models of care they provided varied with EMI homes offering a more clinical and non-EMI homes offering a more social model of care.

Given the emphasis placed in recent and current policy on inter-agency working in order to reduce duplication and improve service delivery, the overall conclusion of this research is to suggest that there is scope for much development. The drive to develop specialist services for people with dementia should, if successful, mean that the large minority of people with dementia currently living in non-EMI Homes should become a thing of the past. However, careful thought therefore needs to be given to the model of care that is to be developed in these specialist services. Currently EMI homes have significantly more Registered Mental Nurses trained in specialist dementia care. This training needs to be further enhanced and extended to other care staff. On the other hand, the greater numbers of regularly visiting professionals and the more community/oriented and social approach to care found in non-EMI homes must not be lost if a service is to be developed that is both skilled and specialist as well as integrated and person-focused. The vision for the future must take into account the new culture of dementia care, which stresses the importance of seeing a person with dementia as an individual with rights and preferences.

This research has highlighted that in order to improve on current practice and enhance the care home experience for people with dementia there must be an increase in:

- Culturally sensitive and person focused practice
- Involvement from community specialists
- Involvement of key workers with relatives
- Respite provision
- Activity staff employed
- Specialist dementia care training for care staff – both qualified and unqualified
- Management training for managers
- Special building design features

Only by addressing these issues can care homes ensure that the quality of service they offer is compatible with the philosophy of the National Service Framework for Older People and the National Minimum Standards of care for homes for older people (Department of Health 2001a; 2001b; 2003). Public and private sectors will need to work together to enable these developments to take shape as without an increase in funding and the expertise of professional trainers the care home sector will be hard pressed to resolve all of the above.

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(1-3) ☐☐☐

MAPPING SPECIALIST DEMENTIA SERVICES IN THE NORTH WEST OF ENGLAND

RESIDENTIAL & NURSING HOME QUESTIONNAIRE

Contact Details

Name of Home: ....

Organisation Name:...

Address:...

....

Postcode ☐☐☐☐ ☐☐☐ (4-10)

Telephone:...

Fax number: ....

Email address: ....

Your name: ....

Your role:

1= Proprietor	5= Nurse in charge
2= Manager	6= Matron
3= Proprietor & manager	7= Administrator
4= Deputy manager	8= Other (please specify)
	....

☐ (11)

☐☐ (12-13)

*** ! REMINDER ! ***

Please send us any documentation relating to your service on the following areas to further inform the North West Dementia Centre's Service Directory

Extra documents enclosed	*(tick box)*
Brochure / other publicity material	☐ (14)
Assessment documents	☐ (15)
Care plan form	☐ (16)

PLEASE RETURN ALL COMPLETED FORMS ALONG WITH ANY OTHER WRITTEN MATERIAL TO:

North West Dementia Centre,
Personal Social Services Research Unit,
Dover Street Building,
The University of Manchester,
Oxford Road,
Manchester, M13 9PL
by 16th April 2001
(Pre-paid envelope enclosed)

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INFORMATION ABOUT YOUR SERVICE

Service Users

1. Please *estimate* the approximate percentage of your residents who suffer from dementia or are confused:

   0 = none 3 = 41-60% ☐ (17)
   1 = 1-20% 4 = 61-80%
   2 = 21-40% 5 = 81-100%

2. Please indicate the lower age boundary for people with dementia being accepted into your facility:

   0= no age boundary 3= 70 years ☐ (18)
   1= 60 years 4= 75 years
   2= 65 years 5= other (please specify) …………………………

☐☐ (19-20)

Please send us any publicity material for your establishment.

3. Does your publicity material specify that you care for people with dementia? ☐ no ☐ yes (21)

Service description

4. Within which sector does your service operate? ☐ (22)
   1=Private 3=Voluntary
   2=Local authority 4=Other

5. Which of the following best describes your facility? ☐ (23)
   1=Nursing home
   2=Specialist EMI nursing home
   3=Residential home
   4=Specialist EMI residential home
   5=Joint registered home
   6= Joint registered EMI home
   7=Sheltered housing
   8=Sheltered housing with extra care
   9= Other (please state) ………………………………………………

☐☐ (24-25)

6. For homes not designated as a specialist EMI establishment (ie categories 1,3,5,7-9 on Q5), how many of your places are specifically designated for people with dementia? ☐☐☐ (26-28)

The building

7. Does your building have any of the following special design features for people with dementia?
   (Tick relevant boxes)

   Specially designed garden ☐ (29)
   Enclosed secure outside space ☐ (30)
   Snoezelen rooms ☐ (31)
   Reminiscence room ☐ (32)
   Name plaques on resident's rooms ☐ (33)
   Uniquely personalised doors (e.g. photographs) ☐ (34)
   Signposting or aids to visual access ☐ (35)
   Uniquely personalised bedroom décor ☐ (36)
   Carpet zoning and guidance ☐ (37)
   Other (please describe) ☐ (38)
   ……………………………..

☐☐ (39-40)

Total capacity / activity

8. How many places/ beds are there in this home (in total)? ☐☐☐ (41-43)

9. How many places are currently occupied today? ☐☐☐ (44-46)

10. Do you offer respite placements? ☐ no ☐ yes (47)
    If yes, are they:
    a) Subject to availability ☐ no ☐ yes (48)
       If yes, how many places are available? ☐☐☐ (49-51)

    b) Specially designated places ☐ no ☐ yes (52)
       If yes, how many places? ☐☐☐ (53-55)

11. Do you provide day care places? ☐ no ☐ yes (56)
    If yes, how many places are there? ☐☐☐ (57-59)

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General Facilities

12. How many resident rooms are there in total? ☐☐ (60-61)

13. How many shared rooms are there? ☐☐ (62-63)

14. How many rooms are ensuite? ☐☐ (64-65)

15. Is it possible for residents to bring:
    - their own personal belongings ☐ no ☐ yes (66)
    - their own furniture ☐ no ☐ yes (67)

16. Are residents encouraged to go to their bedrooms in the day time if they wish? ☐ no ☐ yes (68)

17. Can residents have their meals (other than breakfast) in their room? ☐ no ☐ yes (69)

18. Can residents have visitors at any time? ☐ no ☐ yes (70)

19. With the exception of resident bedrooms, are there places for residents and visitors to be together without disturbing other residents (eg quiet room, visitors room)? ☐ no ☐ yes (71)

Funding

20. What is the most common contractual arrangement for those placements for people with dementia that are not self funded? ☐ (72)
    1= Service agreement with spot purchase
    2= Block contract
    3= Other (please specify) ....

☐☐ (73-74)

21. Please **estimate** the proportion of all residents who are funded by:

Social services ☐☐☐% (75-77)
Self funded ☐☐☐% (78-80)
Health Authority/ Trust ☐☐☐% (81-83)
Other (please specify) .... ☐☐☐% (84-86)

These numbers should add up to 100%

☐☐ (87-88)

Management and staffing

22. How many years have you (the manager) managed care homes? ☐☐ years (89-90)

23. Do you (the manager) have any of the following qualifications?
(Tick relevant boxes)

RGN ☐ (91)
RMN ☐ (92)
SEN ☐ (93)
DipSW ☐ (94)
NVQ level 2 in care ☐ (95)
NVQ level 3 in care ☐ (96)
NVQ level 4 in management ☐ (97)
CSS ☐ (98)
Other (please specify) ☐ (99)
....

☐☐ (100-101)

24. Is your home currently externally accredited by one or more quality assurance programmes?

Investors in People ☐ (102)
ISO 9000 (BS5750) ☐ (103)
Inside Quality Assurance ☐ (104)
Quest for quality ☐ (105)
Other (please specify) .... ☐ (106)

☐☐ (107-108)

25. How many staff work in this establishment? *(Total staff - include domestic, kitchen staff, etc)* ☐☐☐ (109-111)

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26. Within the table below, please complete the three questions (columns) for each of the 6 groups of staff (rows):

	How many whole/ full time equivalent staff are there?	**Which staff receive regular one-to one supervision? (ie regular discussion with their supervisor / shift leader /manager)** (0=no staff) (1= some staff) (2=all staff)	**Which staff have their performance formally reviewed on a regular basis (eg annual appraisals)?** (0=no staff) (1= some staff) (2=all staff)
	(insert number)		
Registered General Nurses	☐☐ (112-113)	☐ (126)	☐ (133)
Registered Mental Nurses	☐☐ (114-115)	☐ (127)	☐ (134)
Senior Care Staff	☐☐ (116-117)	☐ (128)	☐ (135)
Care / nursing assistants	☐☐ (118-119)	☐ (129)	☐ (136)
Social work staff	☐☐ (120-121)	☐ (130)	☐ (137)
Activity staff	☐☐ (122-123)	☐ (131)	☐ (138)
Other staff (please specify) …………………………	☐☐ (124-125)	☐ (132)	☐ (139)

☐☐ (140-141)

27. Within the table below please tell us which groups of staff (if any) have received specialist training in dementia care and what form this takes? ***(Tick relevant boxes)***

	Specialist dementia training				
	No specialist training in dementia care	General induction course on dementia care	External dementia care training course	Informal training with senior members of staff in dementia care	Other (please specify)
Registered General Nurses	☐ (142)	☐ (143)	☐ (144)	☐ (145)	☐………. (146)
Registered Mental Nurses	☐ (147)	☐ (148)	☐ (149)	☐ (150)	☐………. (151)
Senior Care Staff	☐ (152)	☐ (153)	☐ (154)	☐ (155)	☐………. (156)
Care / nursing assistants	☐ (157)	☐ (158)	☐ (159)	☐ (160)	☐………. (161)
Social work staff	☐ (162)	☐ (163)	☐ (164)	☐ (165)	☐………. (166)
Activity staff	☐ (167)	☐ (168)	☐ (169)	☐ (170)	☐………. (171)
Other staff (please specify) ……………………………	☐ (172)	☐ (173)	☐ (174)	☐ (175)	☐………. (176)

☐☐ (177-178)

☐☐ (179-180)

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Resident Focused Care

We are interested in finding out how people with dementia are assessed whilst in your care.

28. Do you complete an assessment form on people with dementia in the first three months after they are admitted? ☐ no ☐ yes (181)
    If yes, please send us copies of your assessment forms.

We would prefer you to send copies of your assessment form, but if this is not possible please complete Q29, otherwise go to Q30:

29. Does your assessment form specify the following? *(Tick relevant boxes)*

Mobility & ADL	☐ (182)	Continence	☐ (188)	What residents want to happen when death approaches	☐ (194)
Daily routine /preferences	☐ (183)	Cognitive patterns	☐ (189)	Carer needs /support given	☐ (195)
Teeth and nutrition	☐ (184)	Depression /anxiety/ /mood state	☐ (190)	Disease /health conditions	☐ (196)
Skin & foot care	☐ (185)	Social /recreational activity	☐ (191)	Medication	☐ (197)
Communication / hearing patterns	☐ (186)	Familiar cultural traditions	☐ (192)	Do residents participate in assessments?	☐ (198)
Vision patterns	☐ (187)	Religious observance	☐ (193)		

30. Do you make a care plan for each service user as a result of this assessment? ☐ no ☐ yes (199)
    If yes, please send us a blank copy of a care plan form

31. Do care /nursing assistants attend care planning meetings? 1= Routinely 3= Rarely 2= Sometimes 4= Never ☐ (200)

32. Do you send copies of care plans to relatives? 1= Routinely 3= On request 2= Occasionally 4= Never ☐ (201)

33. Do you have a planned review of each resident (in addition to those conducted by the social services department)? ☐ no ☐ yes (202)
    a) If yes, how often do you undertake this review? ☐ (203)
    1= Monthly 4= Every four or five months
    2= Two monthly 5= Six monthly
    3= Three monthly 6= Other (please specify) ……………………

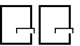
(204-205)

34. Do you routinely invite relatives / carers to your reviews? ☐ no ☐ yes (206)

35. Do relatives /carers attend reviews in your home? ☐ (207)
    1= Often 3= Rarely
    2= Sometimes 4= Never

36. Do you have formal arrangements or resources for involving / sharing the care with relatives? ☐ no ☐ yes (208)

37. Do you have any formal arrangements or resources for providing support for close relatives / friends of residents with dementia? ☐ no ☐ yes (209)
    If yes, please describe ………………………………………………………………………..


(210-211)

38. Which of the following outside specialists visit your establishment and how regularly?*(Tick relevant boxes)*

	Occasionally *(less than monthly)*	Regularly *(once a month or more)*	
Social worker /care manager	☐	☐	(212-213)
Consultant psychiatrist	☐	☐	(214-215)
General practitioner	☐	☐	(216-217)
Community psychiatric nurse	☐	☐	(218-219)
Community nurse	☐	☐	(220-221)
Occupational therapist	☐	☐	(222-223)
Speech therapist	☐	☐	(224-225)
Physiotherapist	☐	☐	(226-227)
Other *(please specify)*	☐	☐	(228-229)

……………………………………………………………

(230-231)

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39. Do you have contact with a specific dementia service in your area? ☐ no ☐ yes
If yes, please provide details……………………………………………………………………………(232)

(233-234)

40. Do you have a key worker / named nurse system in operation? ☐ no ☐ yes (235)
If yes, what do they do for individual residents ……………………………………………………….
………………………………………………………………………………………………………

(236-237)

41. Are people with dementia offered the opportunity to take part in everyday activities which were part of the person's lifestyle prior to admission? ☐ no ☐ yes (238)
If yes, please give an example ....

(239-240)

42. Does your home **employ a member of staff** to run structured activities for residents with dementia in any of the following areas? *(Tick relevant boxes)*

Reality Orientation	☐ (241)	Other (please describe)	☐ (243)
Reminiscence / life story work	☐ (242)	…………………………………………………………	

(244-245)

43. Does your home employ any of the following methods or approaches for people with dementia? *(tick boxes)*

Specially designed building	☐ (246)	Alarm systems	☐ (253)
Unfamiliar placement of door handles	☐ (247)	Tagging devices	☐ (254)
Personalised bedroom doors	☐ (248)	Muted intercom system	☐ (255)
Night lights	☐ (249)	Relaxing music	☐ (256)
Hazard warning symbols	☐ (250)	Good liaison with police service	☐ (257)
Reward systems	☐ (251)	Other (please describe)	☐ (258)
Activity and exercise	☐ (252)	………………………………………………	

(259-260)

44. How many of your current residents are from ethnic minority groups? ☐☐ (261-262)

45. Have you made any of the following special arrangements for people from ethnic minority groups?

Religious observation / spirituality *e.g. areas for prayer/ meditation, links with religious & spiritual bodies*	☐ (263)
Language resources *e.g. translated leaflets, interpreter service*	☐ (264)
Food - diet / storage/ preparation /cooking *e.g. catering for specific dietary requirements*	☐ (265)
Personal care *e.g. provision of appropriate washing facilities*	☐ (266)

46. For residents with dementia do you provide any additional specialist help for sensory impairments (e.g. deafness, blindness)? ☐ no ☐ yes (267)
If yes, please provide details……………………………………………………………………………..

(268-269)

Finally,
47. How much of the questionnaire did you feel able to answer with confidence?

1= All questions	3= Some questions	☐ (270)
2= Most questions	4= Few questions	

OTHER SERVICES & ADDITIONAL COMMENTS

If there are any other services provided by your establishment for people with dementia or *additional comments* you would like to make please make them in the space provided below.

If necessary, please continue on an additional sheet.

……

……

……

……

Many thanks for your assistance in completing this form.
(SEE FRONT SHEET FOR RETURN ADDRESS)

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APPENDIX 2: ADDITIONAL TABLES

Dementia prevalence rates

Although estimates of the prevalence of cognitive impairment vary considerably by the classification system used (Erkinjuntti et al., 1997), the figure we have employed, to estimate the number of dementia cases within each local authority in the North West, is 9.3 per cent of over 65s, derived from the Hofman et al., (1991) study. This major demographic study pooled 23 datasets of European studies. It is also important to note that estimates from the United Kingdom suggest there will be a 50 per cent increase in the total number of persons age 65 and older with cognitive impairment over the next 25 years (Ely et al., 1996; Melzer et al., 1997).

Table A1: percentage of dementia cases in people over 65 years of age group

65-69	**70-74**	**75-79**	**80-84**	**85-89**	**90-94**	**95-99**	**Total over 65**
25/1740	64/1559	125/2203	189/1453	258/1197	115/357	24/69	800/8578
1.4%	4.1%	5.7%	13.0%	21.6%	32.2%	34.7%	9.3%

Source Hofman et al., (1991)

Table A2: Total places, occupancy and numbers of residents from ethnic minority groups

Local Authority	Home	Total places	Places currently occupied	Number of residents from ethnic minority groups	Per cent ethnic minority population over 65*	Estimated no. ethnic minority residents to total places	Estimated no. ethnic minority residents to occupied places
Cumbria	51	1443	1369	2	0.9	13	12
Bolton	6	340	307	1	5.0	17	15
Bury	3	300	255	4	3.5	10	9
Manchester	11	544	478	18	9.2	50	44
Oldham	5	171	143	0	5.4	9	8
Rochdale	6	271	227	6	5.3	14	12
Salford	3	134	35	0	2.3	3	1
Stockport	21	631	597	6	2.6	16	15
Tameside	20	709	617	4	3.6	25	22
Trafford	5	163	154	3	4.5	7	7
Wigan	6	233	200	0	1.0	2	2
Knowsley	4	157	146	1	1.3	2	2
Liverpool	11	532	475	16	3.2	17	15
Sefton	17	621	584	4	1.3	8	7
St Helens	6	194	173	0	0.9	2	1
Wirral	10	395	360	0	1.4	5	5
Cheshire	24	909	849	6	1.5	14	13
Halton	3	63	52	0	1.0	1	1
Warrington	5	211	192	3	1.4	3	3
Lancashire	43	1820	1548	14	2.3	42	35
Blackburn with Darwen	18	365	329	1	7.1	26	23
Blackpool	8	174	166	3	1.2	2	2
Total	286	10500	9361	92	2.7	283	253

*Excludes Irish, includes 'other white' (2001 census)
Source: questions: 8, 9, 40

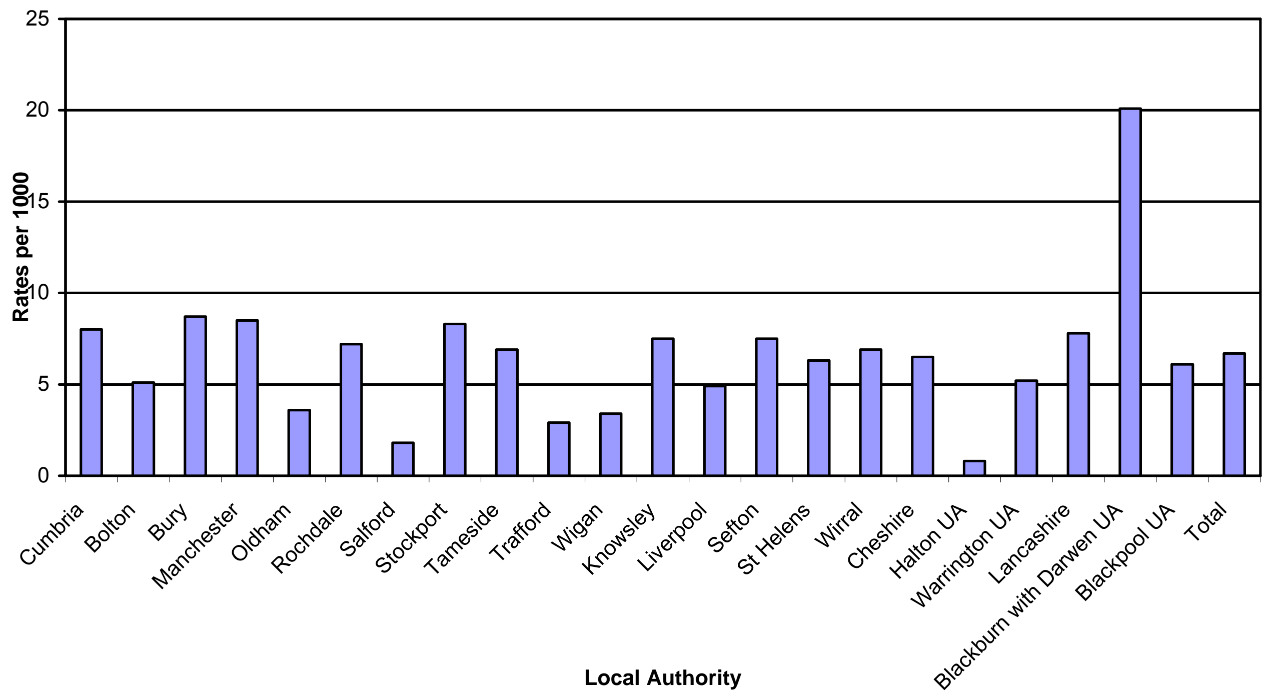
Table A3: Accreditation programmes by home types

	Nursing		Residential		Dual		EMI		Non-EMI		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Investors in people	24	32	52	38	16	21	40	25	52	42	92	32
ISO 9000 (BS5750)	16	21	5	4	7	9	21	13	7	6	28	10
Inside Quality Assurance	5	7	19	14	7	9	19	12	12	10	31	11
Quest for quality			3	2	1	1	4	2			4	1
Other quality assurance programme	2	3	7	5	8	11	10	6	7	6	17	6

Source Question: 24: Is your home currently externally accredited by one or more quality assurance programmes?

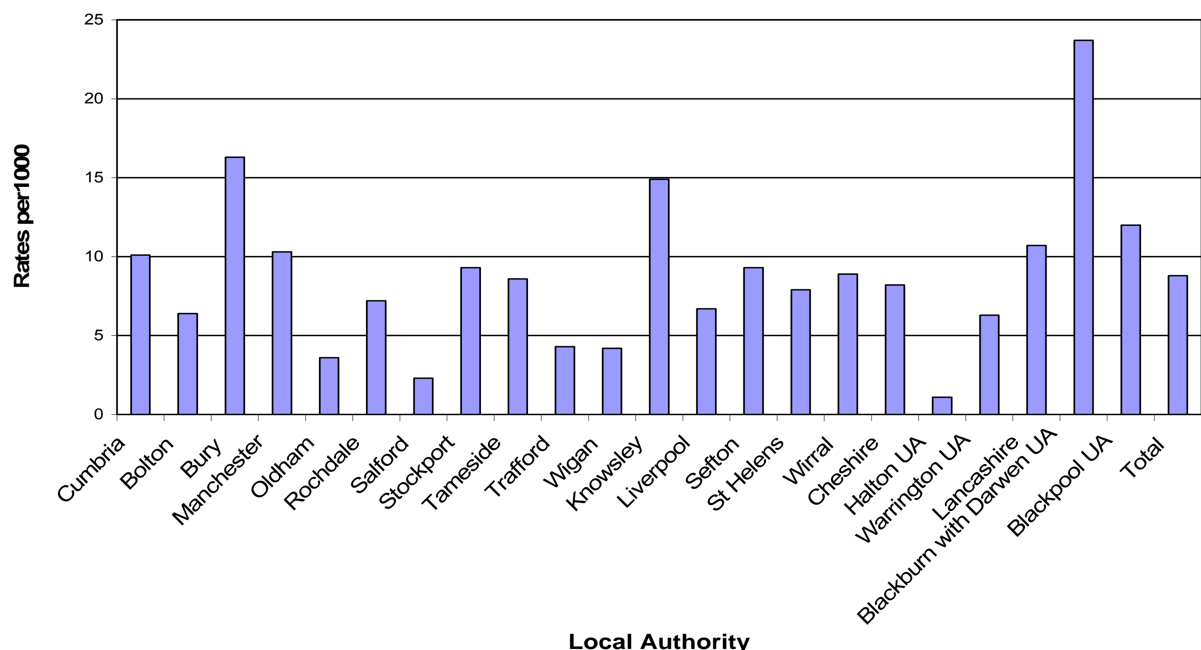
APPENDIX 3: LOCAL AUTHORITY CHARTS

Figure 3.1 EMI places per 1000 (recorded)



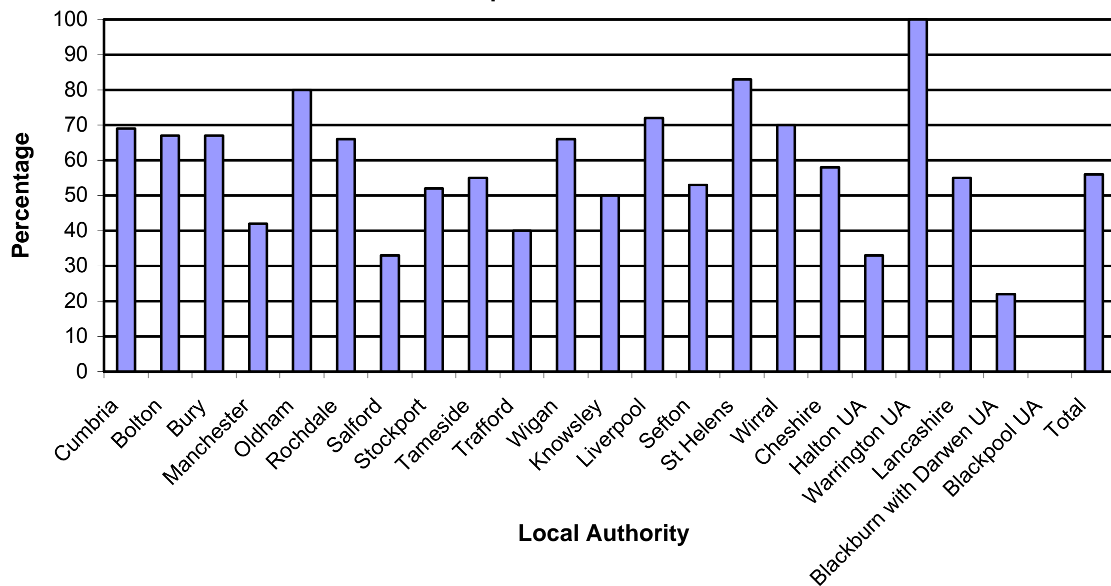
Source Questions: 5: Which of the following best describes your facility; 6: For homes not designated as a specialist EMI establishment, how many of your places are specifically designated for people with dementia?; 8: How many places/beds are there in this home in total?

Figure 3.2 EMI places per 1000 (estimated)



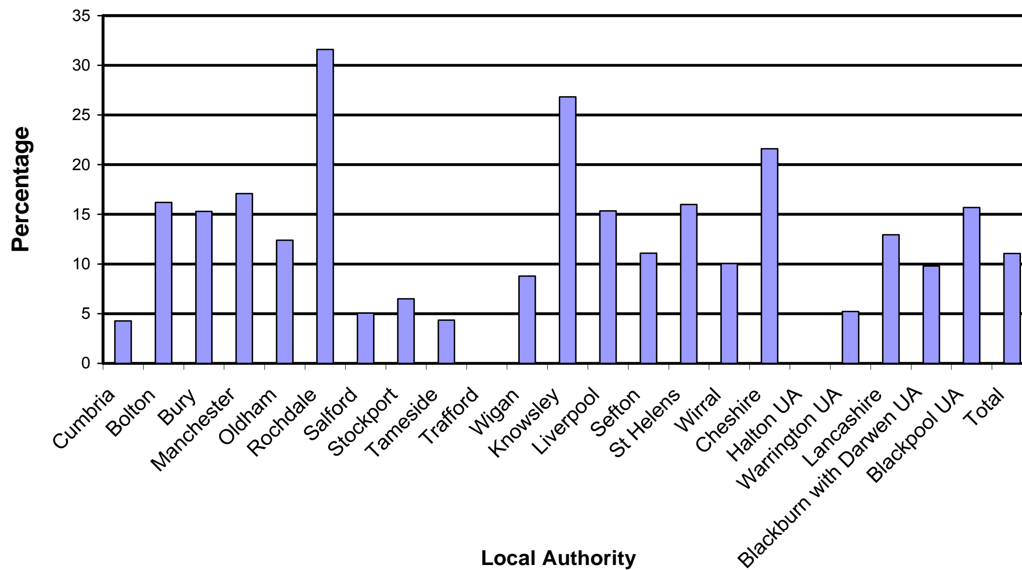
Source Questions: 5: Which of the following best describes your facility?; 6: For homes not designated as a specialist EMI establishment, how many of your places are specifically designated for people with dementia?; 8: How many places/beds are there in this home in total?

Integration and access to specialist input



Source Question: 38: which of the following outside specialists visit your establishment and how regularly? (*Tick relevant boxes)*

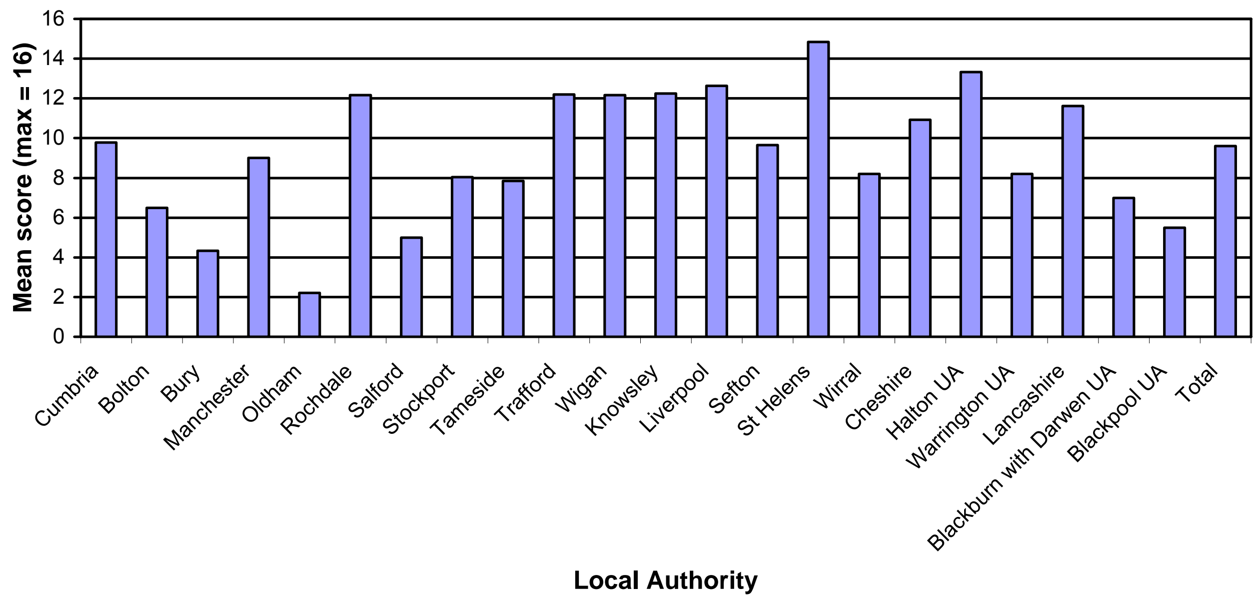
Staffing



Source Question: 26: How many full time equivalent staff are there?

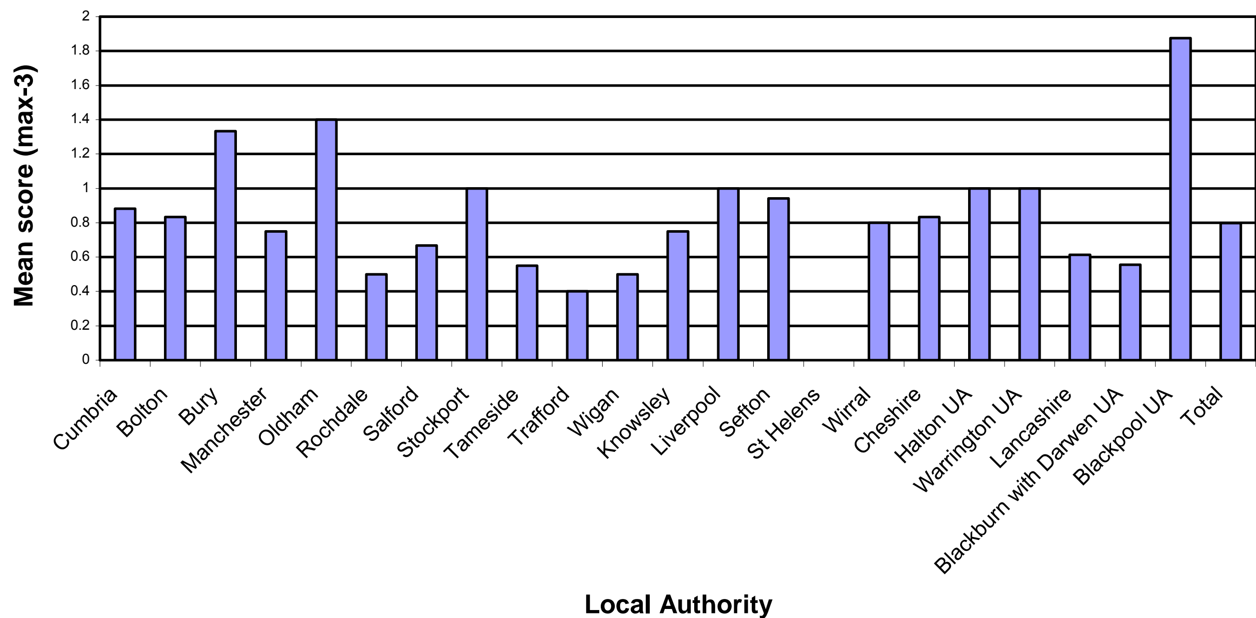
Assessment and care planning

Figure 3.5 Mean number of assessment categories covered



Source Question: 29: Does your assessment form specify the following…?

Figure 3.6 Care plans meet NSF criteria



Source: Care plan post coding sheet

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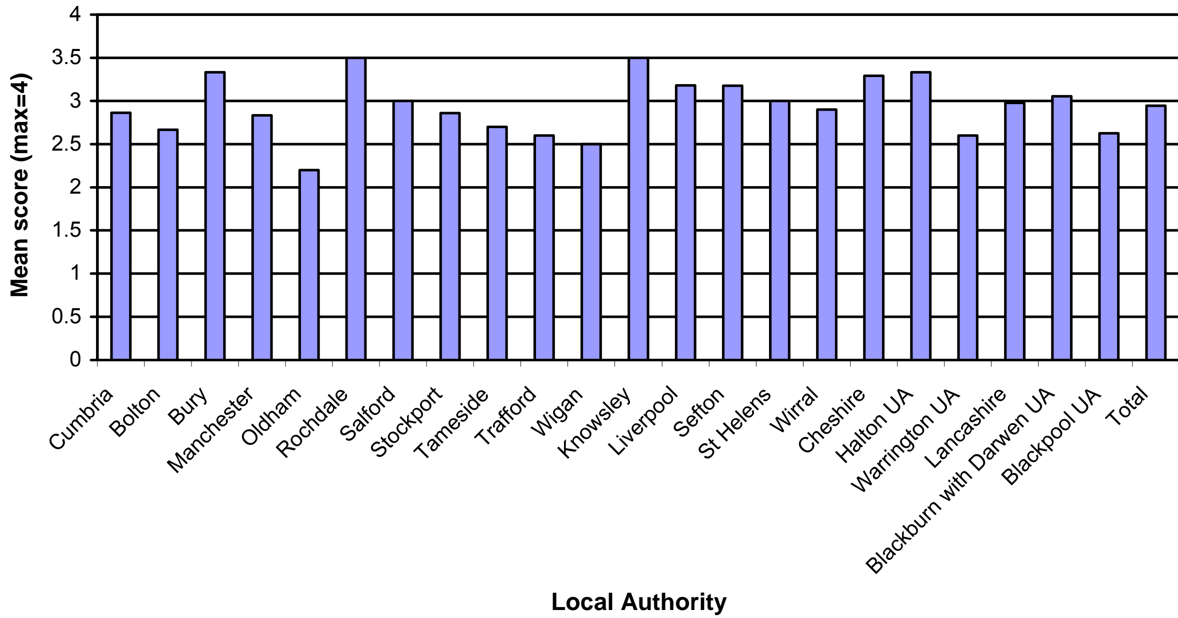
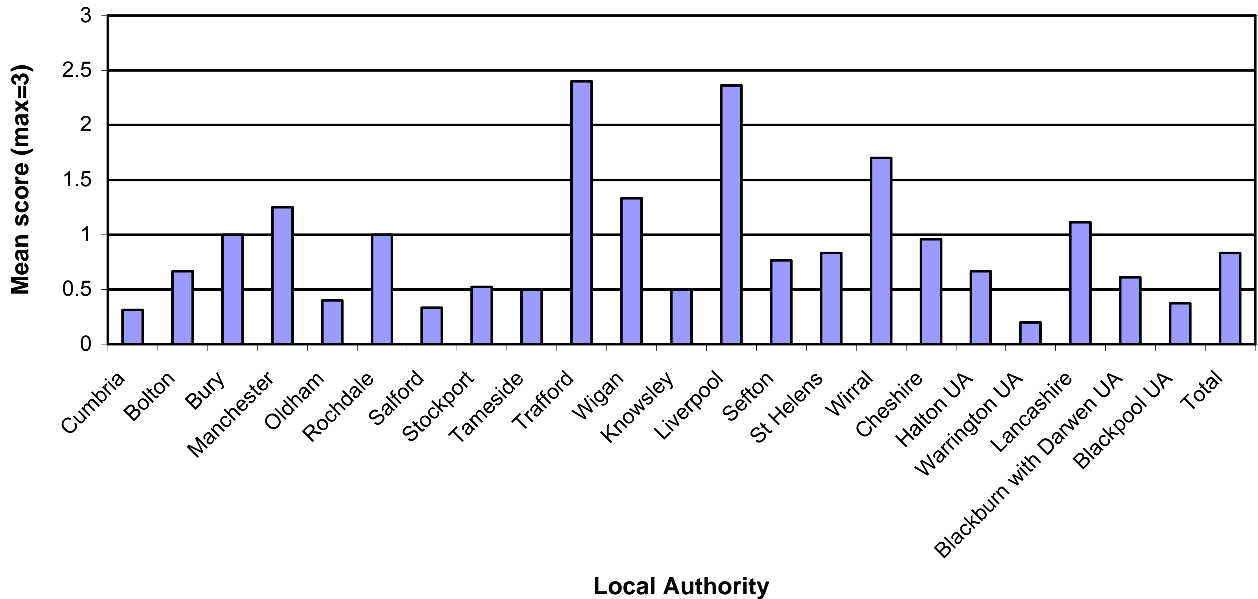
Figure 3.7 Systematic assessment



Source Questions: 28: Do you complete an assessment form on people with dementia in the first three months after they are admitted?; 30: Do you make a care plan for each service user as a result of this assessment?; 33: Do you have a planned review of each resident in addition to those conducted by social services?; 34: Do you routinely invite relatives/carers to your reviews?

Equity of access for ethnic minorities

Figure 3.8 Special arrangements for ethnic minority residents



Source Question 45: Have you made any of the following special arrangements for people from ethnic minority groups…?

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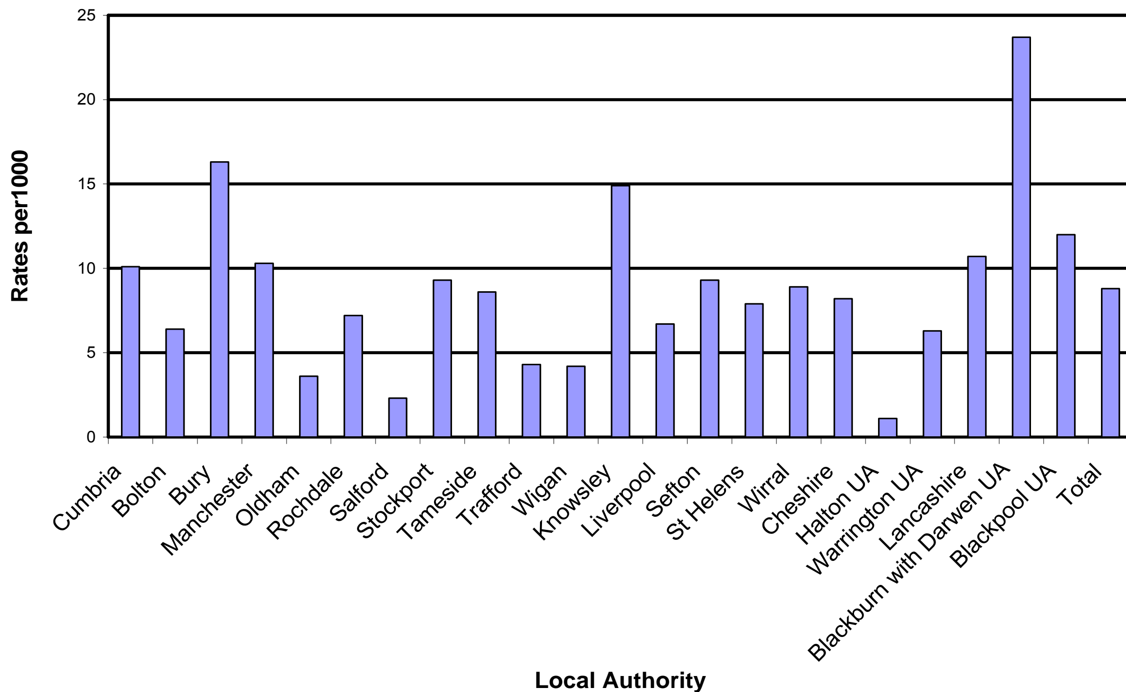
Targeted service

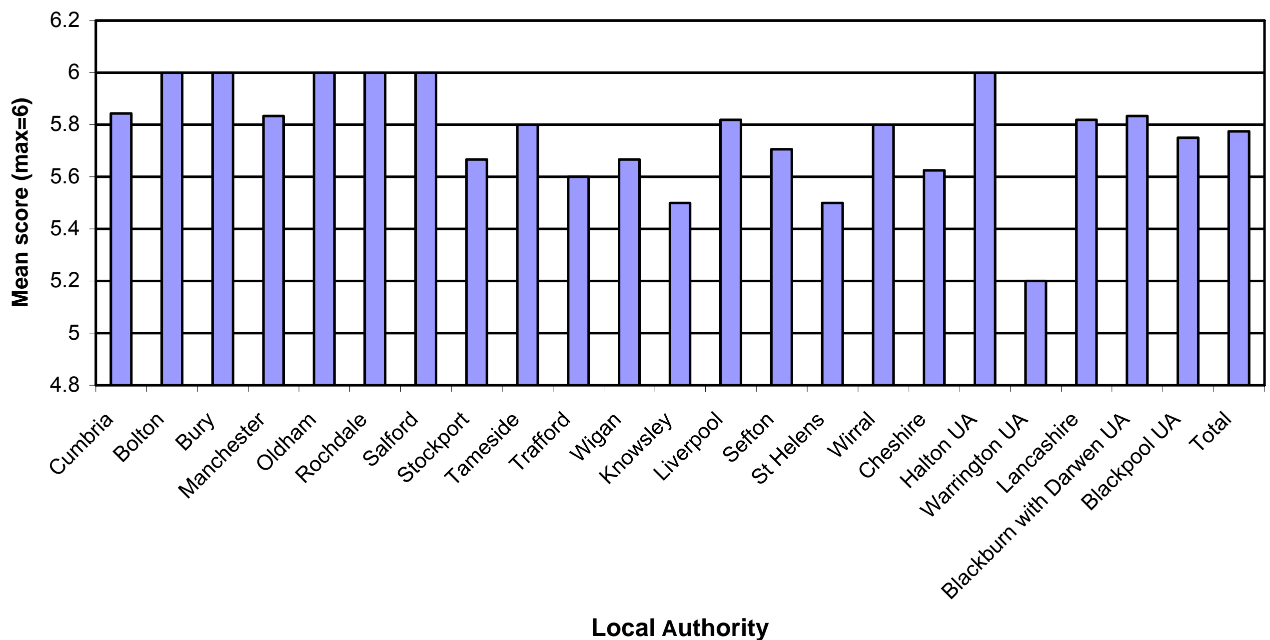
Figure 3.9 Service targeted at people with dementia



Source Question: 1: Please estimate the approximate percentage of your residents who suffer from dementia or are confused; 4: Within which sector does your service operate?; 5: Which of the following best describes your facility?

Independence

Figure 3.10 Good practice to promote independence



Source Questions: 41: Are people with dementia offered the opportunity to take part in everyday activities which were part of the person’s lifestyle prior to admission?; 15: Is it possible for residents to bring their own personal belongings/their own furniture?; 16: Are residents encouraged to go to their bedrooms in the day time if they wish?; 17: Can residents have their meals (other than breakfast) in their rooms?; 18: Can residents have visitors at any time?

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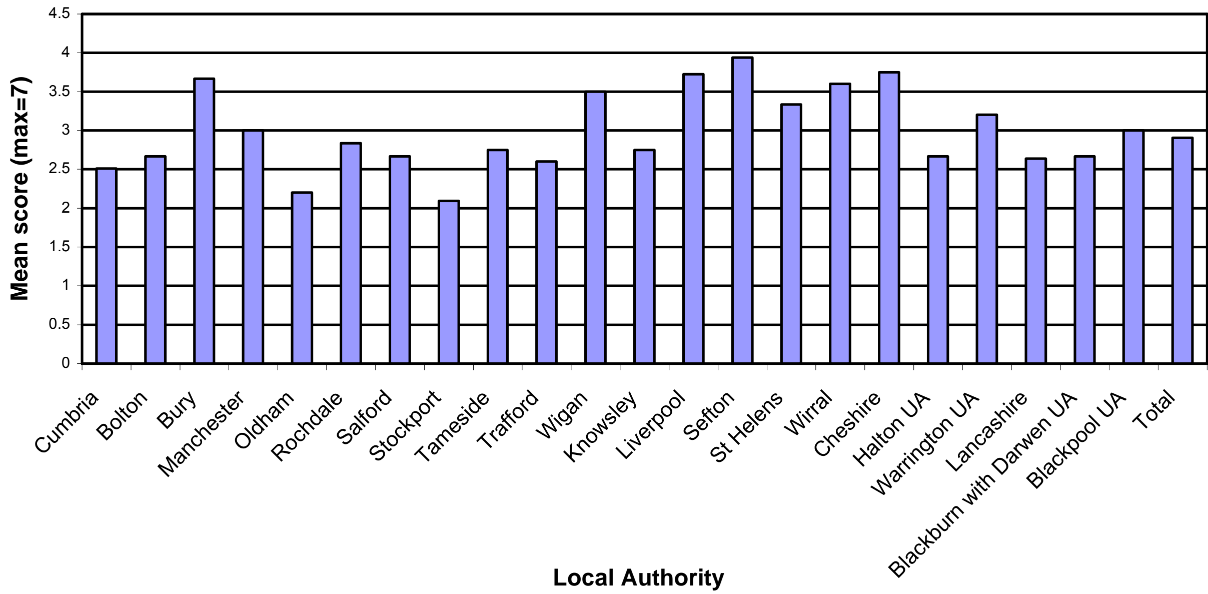
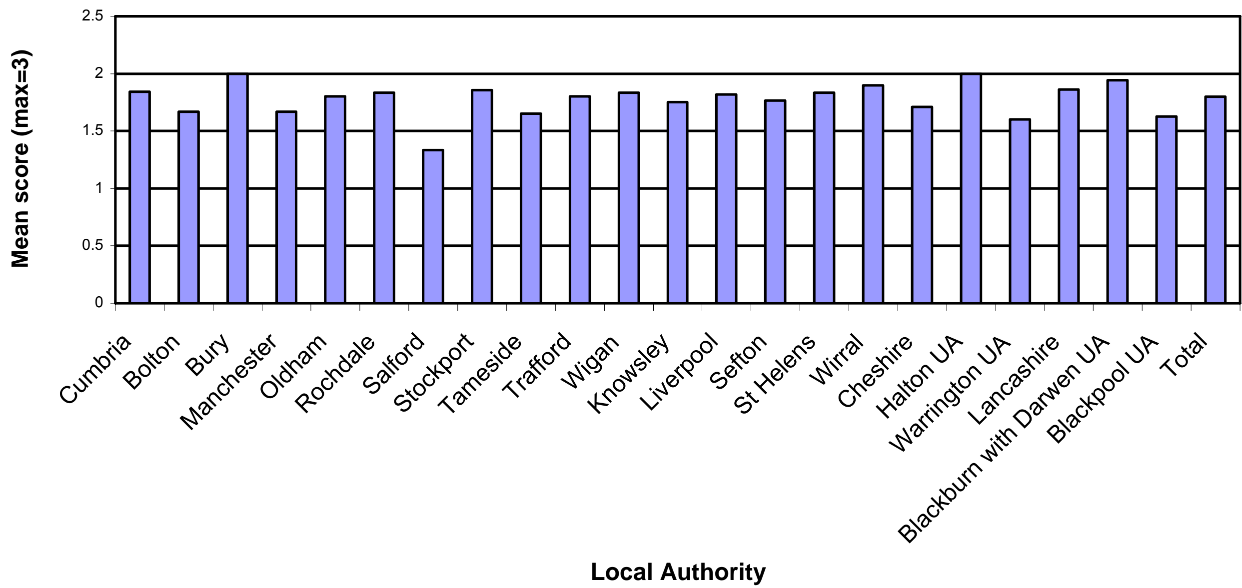
Figure 3.11 Building design to promote independence



Source Question: 7: Does your home have any of the following special design features for people with dementia?

Privacy

Figure 3.12 Privacy measures



Source Questions: 13: How many shared rooms are there?; 14: How many rooms are ensuite?; 19: With the exception of residents bedrooms, are there places for residents and visitors to go together without disturbing other residents?

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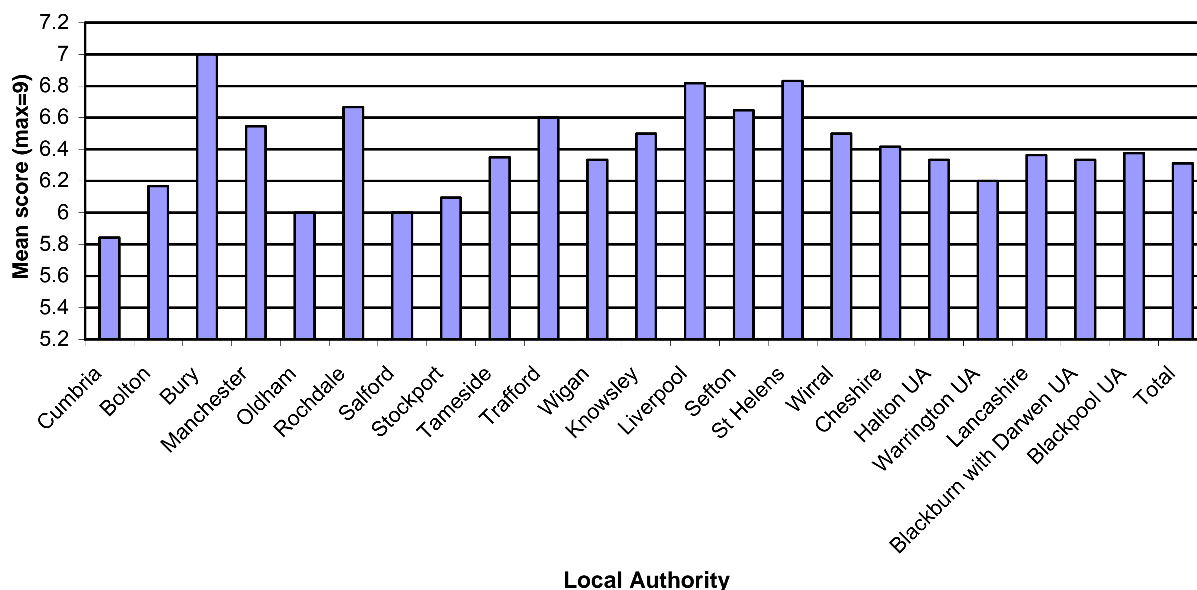
Person focused care

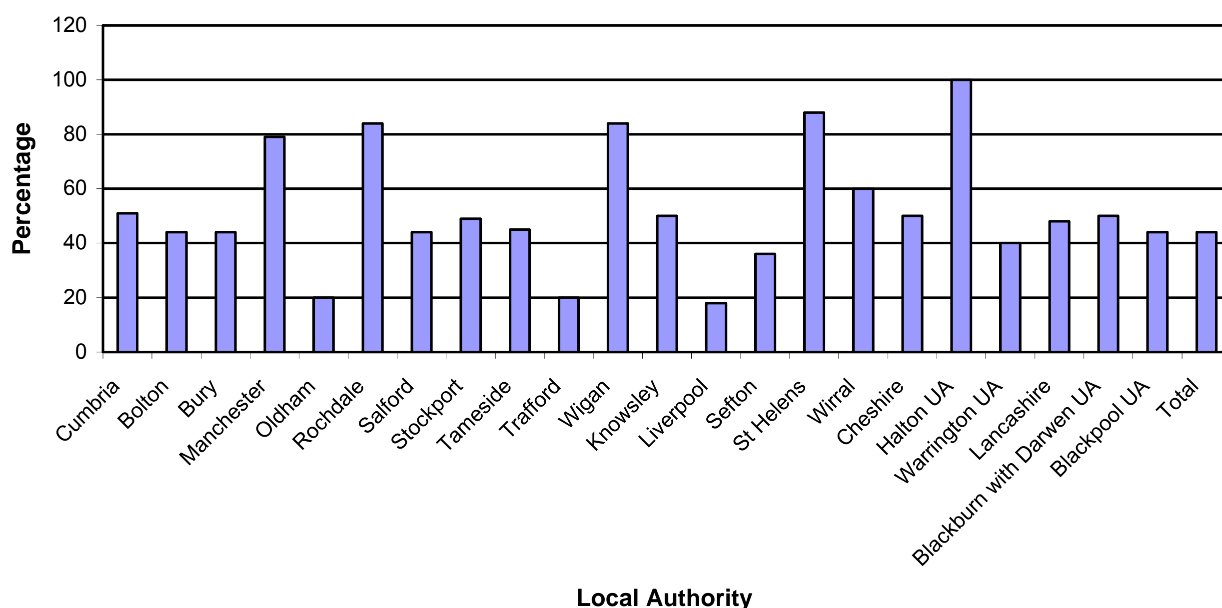
Figure 3.13 Individuality measures



Source Questions: 7: Does your building have uniquely personalised doors/uniquely personalised bedroom décor?; 15: Is it possible for residents to bring their own furniture/personal belongings?; 28: Do you complete an assessment form on people with dementia in the first 3 months after admission?; 30: Do you make a care plan for each service user as a result of an assessment?; 40: Do you have a key worker system in operation?; 41: Are people with dementia offered the opportunity to take part in everyday activities?; 46: For residents with dementia do you provide any additional specialist help with sensory impairments?

Specialist training

Figure 3.14 Homes with some staff with dementia care training



Source Question: 27: Please tell us which groups of staff have received specialist training in dementia care and what form this takes…

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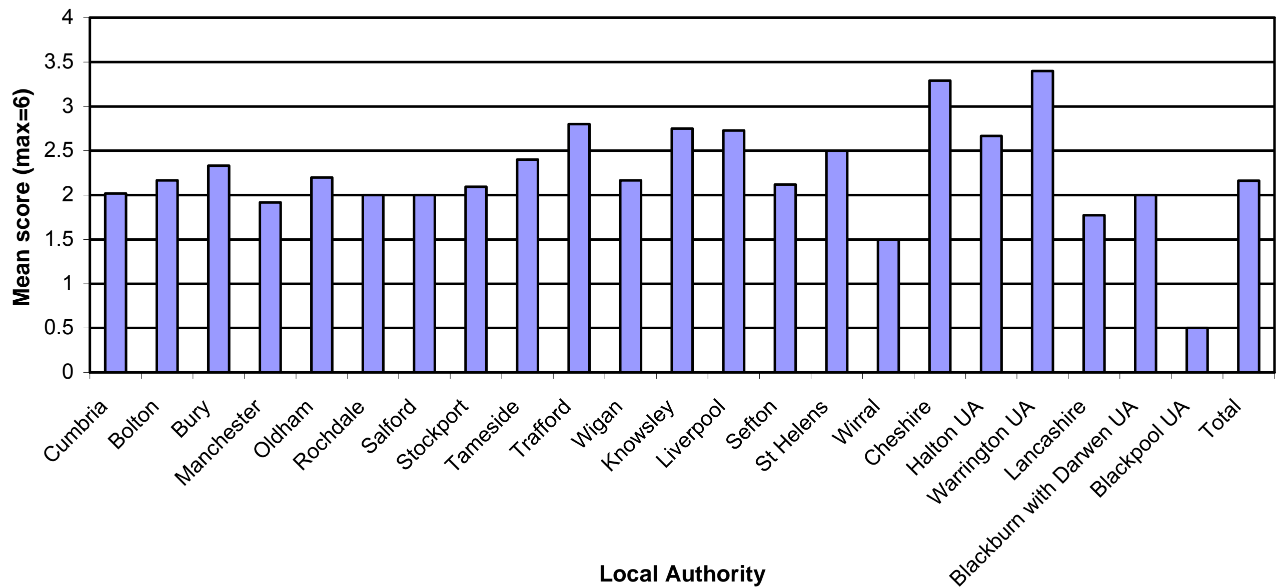
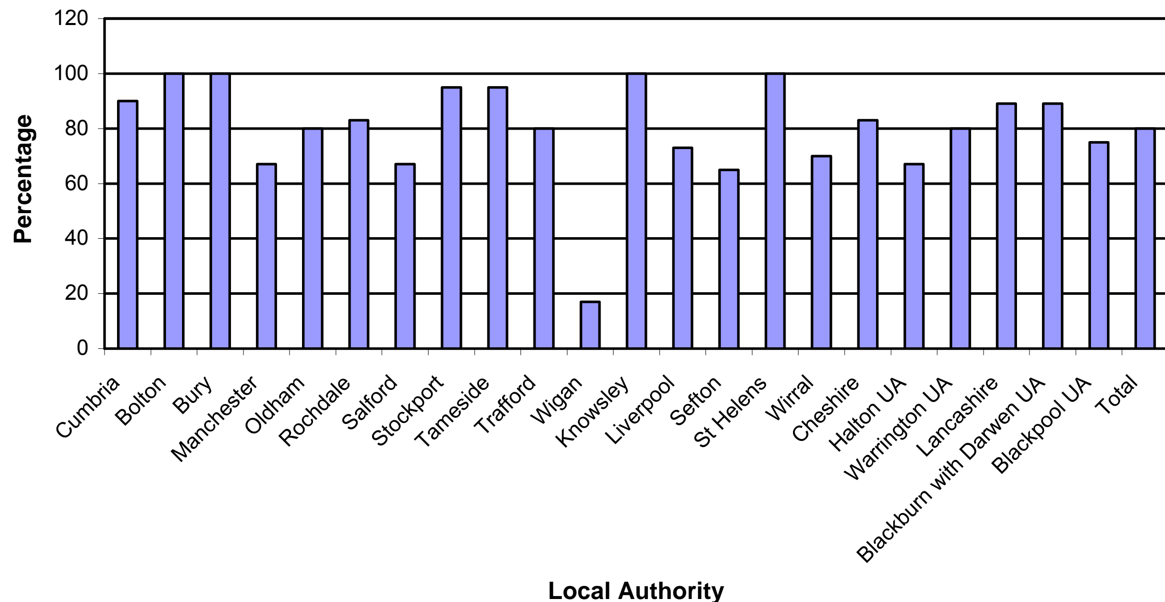
Carer involvement

Figure 3.15 Carer support



Source Questions: 29: Does your assessment from specify carers needs?; 32: Do you send copies of care plans to relatives?; 34: Do you routinely invite relatives/carers to reviews?; 35: Do relatives/carers attend reviews in your home?; 36: Do you have formal arrangements or resources for providing support for close relatives/friends of residents with dementia?

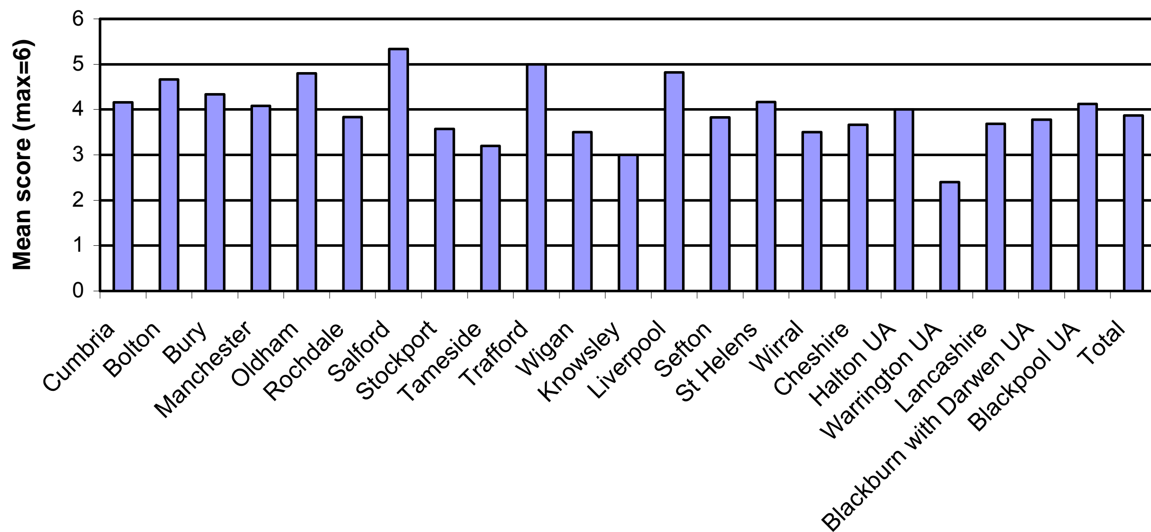
Figure 3.16 Percentage of homes with one or more respite bed



Source Question: 10: Do you offer respite placements?

Management and care worker good practice

Figure 3.17 Practices measuring care worker good practice



Source Questions: 26: Which staff receive regular one to one supervision? Which staff have their performance formally reviewed?; 27: Which groups of staff have received specialist training in dementia care?; 31: Do care/nursing assistants attend care planning meetings?; 40: Do you have a key worker system in operation?

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