003.005

Speaker key

RE Researcher
SM Staff Member

RE Okay, so that's perfect. So, just to introduce myself again: As you know, I'm conducting this research as part of my work at xxx, and everything you talk about is confidential. But, if you just introduce yourself for the purpose of the transcription, then we take your name out afterwards.

SM Oh, okay, great. Oh well, I'm xxx, manager of xxx

RE Great. Okay, thanks again for agreeing to take part in the interview. So, I don't know how much... you've seen the information sheet that I sent you.

But, as part of the , I'm interested in how people working in Care Homes and running Care Homes, think about and cope with residents who are agitated. And, I suppose, when we're talking about agitation, we're referring to behaviours that can be difficult to manage; so things like restlessness, pacing, shouting, verbal aggression, physical aggression. And we're asking because we know that it's something that you and your colleagues manage a lot, and want to make use of your expertise.

We're doing these interviews because we're hoping to develop an intervention that will be delivered via staff. So it's sort of an intervention to be delivered to staff for them to roll out in Care Homes. And we want to make sure that we develop something that actually fits with the reality of the busy day to day life in a Care Home, rather than us kind of going on; this is what we think you should do, and then it not working. So, we're sort of trying to do all this first.

As I say, it's being recorded, but we will anonymise all the material, so we'll take out your name and any names of residents or staff that you mention.

SM I'll try not to; I'll try to... not.

RE Is there... just that it makes it easier when I... that I don't have to go through the names. But, if you do, it's not a problem.

SM Okay.

RE Obviously, if you do tell me something that I'm concerned about in terms of people possibly being harmed in some way, I would have to talk to you about raising that elsewhere.

SM Sure.

RE Because we can't kind of keep things a secret if we think someone's being harmed.

SM Yes.

RE If you need to stop at any point, just tell me. It shouldn't be distressing.

SM If it gets there [overtalking]

RE No, no, it's not a very heavy interview; but more if someone needs you for something; a bit of petty cash, or...

SM Okay.

RE So, is there anything you want to ask before I start asking you questions?

SM No, no, no. It's fine, yeah.

RE Okay, good. So, just to start off, can you, first of all, think of a resident that you know well here, who does get agitated. And you don't need to tell me their name, obviously; but can you just tell me a bit about them and their behaviour and about what happens when they become agitated.

SM Okay, there are a number of clients here but I'll focus on just one.

RE Yeah, I mean, you can talk about a few, but if you start with just one, and we talk about that in detail, and then if there's...

SM Okay, we have a lady here, who can become verbally quite aggressive, and also physically, if her perception thinks it; if things aren't the way she thinks, or she perceives someone is... Well, for example; yesterday, one of the things was; she assumed that someone was going to come take something off her, and she immediately hit out, and of course that wasn't the case; nobody was trying to take anything.

RE Was that towards a staff member? Or...

SM No.

RE Or towards another resident?

SM No, another resident.

RE Yeah.

SM Fortunately there were staff members there and myself as well, at the same time.

RE Yes.

SM And we were able to sort of just talk to her and calm her down and tell her that nobody's taking anything away. And it was fine, she kind of got it. But it was just that initial... they're going to take something off me; something like this. Holding it to her and punching.

Yes, so, I mean her behaviour... she did... it tends to be more verbal, that she'll get upset and angry with people, but her perception is; she doesn't perceive things, quite what's going on, sort of like a receptive sort of thing, she's not really picking up what's going on.

RE Okay, that's fine, so you were saying that this is someone who, when she perceives that something might be, like be taken away…

SM Yes, and it's not necessarily what's happening around her, it's actually quite difficult to find the triggers. I think from my point of view, I don't deal well with people I don't know. If I know them and I know how they operate and what their interests are and how you can distract them, then it's much, much easier to do that. So I think the relationship side of it is a huge thing, for me. Yes, that particular lady, yes, it's easy to distract her once you know what the distraction points are, but you can take away from, like a cup of tea, or come and sit, she likes to sit down and have a little chat, things like that. So if you know what can be done…?

RE And is that about knowing what she likes and getting to know her?

SM Yes, but I think that's true of all of our clients. There is one dementia client here that just won't let me anywhere near, absolutely not, there's an immediate dislike straightaway.

RE And are they like that with everyone, or are there other people that they have a connection with?

SM The majority, yes, but they do have a connection with one or two folks, which is quite nice to see, that they've actually got some people that they can get on with. There's no way in, there's just no way in.

RE Yes, and I think sometimes that happens doesn't it.

SM Yes, but it's to be expected.

RE Yes, and so with this lady, when she talks like that, you've sort of talked about maybe that she's misperceiving things, but do you think there's anything else that actually causes that agitation to happen or causes her to get…

SM Yes, what causes her to become anxious. She has sort of her own set routine, and she does like to wander. People get a little agitated with her because she wanders, the staff, you sort of don't…

RE Does she like to sort of walk round the unit or…?

SM No, what she does is she will walk to the lifts, up to her floor, walk around the floor, come back in the lifts downstairs again, wander, she just likes to be able to wander. There's nothing stopping her doing it, she's not doing any harm or anything. Occasionally she's managed to end up in the basement, once she ended up in the basement, and got quite distressed because it was completely unfamiliar.

For her I think it's a matter of unfamiliarity, knowing where she is and what time of the day it is, and what's going on, her routine, it's very very important. If anything upsets her I think she becomes very anxious, it doesn't make much.

RE Yes, so sort of having the right routine, being in familiar surroundings. You were saying she also likes being able to kind of wander around.

SM Yes, she doesn't try to leave the building, she's not that bad, but she does like the freedom of just being able to get up and go whenever she wants to and go back to her room. On her floor there's a lounge up there, go up to the lounge up there. But she also quite likes the people, so she will also gravitate back downstairs again.

RE Yes, and is she someone, I mean, that the staff get kind of worried about wandering around like that.

SM I think they do, because she's not sort of staying in one place. So I think there's a perception that she's going to be harmed in some way by coming up and down in the lift or something, being on her own, so I think there's a…. it's wanting to care, and wanting to care well, but it's finding the least restrictive way of doing that. I think for her, if we were to try and hold her in one place, then she really wouldn't understand what we were doing, she would get quite agitated and angry, and then probably hit out.

RE Yes. Do you think there's any other things that might be causing her agitation or anxiety, you mentioned quite a few already, but…

SM I think other clients can as well, because they become agitated, she becomes agitated, she doesn't like trouble, if you know what I mean. Fortunately, it does happen occasionally, when people have a little shout and things, that's bound to happen, but she doesn't like it, that gets her back up.

RE So if people are kind of noisy or kind of…

SM Yes, I can imagine that she was probably a peacemaker in her home, she didn't like any trouble, she probably compromised a lot, you can just see her sort of taking the edge off arguments, because she doesn't like the noise.

RE Yes. So it's about kind of getting to know her and understanding what she might have been like before as well.

SM Yes, that comes from talking to the families as well. She has a daughter who visits almost every day, that's quite, that's good. That's good for her as well, because she recognises her and she knows that she comes to visit and she knows that she's going away again and it just sort of grounds her a little bit, she comes five afternoons

a week, when she finishes work, so I mean that's quite a lot, it's a big commitment. But it does help her, it's good for her.

RE Yes, that is a lot isn't it. You were saying you've got quite a number of residents who can become agitated at times, are there others that are a bit different from that?

SM Oh, yes, there are others who are vastly different from that. I take somebody from the fourth floor, a chap who…

RE So sorry, do your floors, do your people get more severely…

SM We have two dementia floors. Third floor is dementia but quite often a lot of them come downstairs as well. Some of them don't, some of them choose, because they don't like big crowds and big open spaces, so they don't come downstairs. The chap I'm thinking of now is actually on the fourth floor, which is where they have some behavioural issues. Actually we're very lucky here, because we don't have that many behavioural issues as such. They all tend to focus around personal care. I think there's a lot of work to be done in that area, some of our carers are very natural and amazing and just manage to be able to explain, almost without explaining, what they're going to be able to do, and keep a situation calm by the tone of their voice and all that sort of thing. So when they wash and dress someone, they don't have any problem. But then somebody else will come in who is perhaps trying to get on with the job, get things done, let's get this moving, and maybe not explaining things well and that's when problems can arise. So a lot of it is focussing on the client you're with, and allocating the time, time management is a big thing for dementia patients, for the staff. I think it's one of the problems. You will get very efficient staff who don't develop a relationship with clients, and I find I tend to put them not on dementia floors, because I think it causes problems. You do get people hitting out and not understanding and being aggressive and challenging.

But this chap that I'm thinking of is actually on the fourth floor, and he had to come into hospital, actually , surprising, with a UTI, but was found wandering, and his dementia is one where he has hallucinations as well, so that's different from someone who is just… so he was talking about fires and floods and no children, never married, lots of nieces and nephews, so we've managed to gather a little a bit about him.

But I mean, he was a GP, he worked all the hours God sends, I have a sneaky suspicion that he probably did have a male partner at some point in his career, but obviously that, he would never never talk about that, so that's not a subject you can bring up. He can become quite physically, I mean, he has put a fire extinguisher through the fire door, ringing fire alarms….

RE And does that… you mentioned about hallucinations and about floods and fires and stuff, do you think that that connects?

SM Well, I've spoken to his family and as far as I know, he's never been in a fire or a flood, but they have said that he's always been a worrier, he's always worried about money, he doesn't seem to be talking about that too much anymore, he's always worried about being away from home, which he stills talks about from time to

time, so it's obviously still a concern for him, because he's Scottish, that he's not in Scotland anymore. He has to go back there, so it's being away from home.

The last couple of years in the community the warden had said that he had been talking about the neighbours, the neighbours talking about him, at night when he was in bed and he could hear them, it just wasn't possible apparently and that there was a fire and people needed to evacuate the building, or there was a flood. So he probably always was a worrier.

You can actually see, he was probably a damned good GP.

RE Yes, he was probably very thorough.

SM Yes, exactly.

RE And so how long has he been with you?

SM He's been with us for about eight months.

RE Okay, and so is it that he doesn't want people to help with his personal care or is it that he…?

SM No, his issues are not about personal care, he actually does himself, he's pretty independent, we just need to check, sometimes he won't wear underpants and sometimes he won't wear socks, that sort of thing. But he's very clean, no issues there at all. It's more at other times, that he gets frustrated, and wanting to leave, and feels that he must be somewhere. But what we have found with him, is that if we bring in, particularly in the summer time, which is great, we could take him into the garden, a little walk around, get outside, I'm sure he was quite an active person all of his life, so we take him out as best we can, and his friends, he has two or three friends that come and take him out, so we encourage him them to get him away from the building, so he's having something else, and that actually helps him quite a bit.

RE Yes. Well, so you were saying that actually if he is encouraged to go out or people are able to take him out [overtalking].

SM We realised it when his friends came to take him out. Then if he was out for an hour and came back, just to the, walk to the little coffee shop round the corner, have a cup of coffee, walk back again, then he settled for the rest of the day. Actually it was quite good. I mean, we've had a lot of input with him from the Community Mental Health Team as well. They've been fantastic. And they've, sort of, gone into his background and his history, as much of it as we can do because, of course, nieces and nephews who have lived quite a distance away don't really know the ins and outs of someone's lives. I get the impression that his life was quite secretive, his personal life at least. But just that, if he does get agitated like that then what he really needs is to get out. He does need to get out, so he's… whether his brain is telling him it's a fire or it's a flood or he's got to go to the bank to sort out finances, whatever it might be, he just needs a little bit of time outside.

RE I was going to say, you know, what is it do you think that, sort of, underpins that need to get out?

SM I think it's a feeling of, a sense of being trapped. And I know that when he, when he'd been with us for a little bit, I mean, his, the closest niece, he lived in xxx, but the closest niece lived in xxx, so we're not talking about people who live close by. Nieces and nephews… one of his nephews came from xxx, one was over yesterday from xxx, I mean, they're just all over the place. So, nobody lived close to him and nobody really knew him that well and… yes.

RE So, it's, kind of, piecing things together for him.

SM It's trying to piece it together for him because he is a very private person. If you were to ask him a direct question he probably wouldn't answer it. But if you can get him engaged in a conversation in something that he's interested in… he's very interested still in medicine and exercise and things like that. We did try to bring him down to the exercise classes but he panics in a large group. We did bring him because it was outside to the barbecue in the summer but he panicked. He literally had a panic attack because of the crowds of people. So, in one way he wants to be outside but he doesn't want to be in a crowd. So, it's quite difficult. And the instances of him becoming agitated have got less and less.

RE Yes.

SM Partly it's been through medication.

RE I was going to say, so, what's worked? What's been tried? And you mentioned the Community Mental Health Team.

SM Yes, I mean, they came, I can't remember what exactly they, I know they put him on risperidone for a little while but he's off that now which is quite good. Oh, zopiclone at night to make him sleep because he wasn't… the anxiety was just, anxiety was quite horrendous for him. But I think what he appreciates is one to one. He doesn't cope well in groups and he doesn't like groups and that makes it very difficult then anywhere in the home because they're, kind of, stuck with people around him the whole time. So, it was easier for him to be on the fourth floor where there were less people. There are only ten people up there with himself, so there are nine others at the moment. And some of those come downstairs at times so, you know, sometimes there's less. But it's still quite… I find it quite distressing that he's, he is limited and we have a DOLs on him simply because we have to, not for any other reason because he really wouldn't… if he did go out on his own he'd never be able to find his… he wouldn't remember he was living here or where he was.

RE No, no.

SM But physically, he's quite fit.

RE But actually there's something about, kind of, him, sort of, needing to be able to, kind of, escape or, kind of, get out.

SM He still, yes, I mean, he still needs to feel that he's got freedom. And that's the key for him I think is to allow him as much freedom as we can but keep him safe. So, we try and bring him, we tried to, but it's very difficult now that it's so cold and wet and everything, but we try to put it into his, that he would, put it into his care plan that he would, either his friends or us would take him out each day. And on the whole that worked.

RE And, because obviously, you're the, kind of, overall manager so, it sounds like you're quite hands on in lots of ways but presumably not as much as you would like [overtalking].

SM Not as much as I would like. Yes.

RE You have got lots of other things to do. So, how, what do you see the, sort of, staff doing that, kind of, works well with these more difficult to manage people, you know, what do you, kind of, see other people doing that…

SM Well, in fact, I have seen staff, when he was getting very agitated and, I can't remember if that was a fire or a flood time really, but he was getting really agitated and one of the staff said, oh, do you mind if you have a look at my back, it's been quite bad? And it immediately distracted him and he went, certainly, of course. And, you know, went along and they had a little poke around, I can't see anything wrong here, are you sure… it might be muscular. So, I mean, it just took his mind off it completely. So, that was, that was quite amazing because I would never have thought of doing that.

RE No. Quick examination.

SM Yes, why don't you just… but that was what it was and it just distracted him and he said, yes, and did it and… yes. So, yes, that sort of distraction was very good. But also sitting and talking to him because I think he's very sensitive about not being listened to. Which is not the same as being ignored if you know what I mean. But actually not being listened to. So, if he's saying we have, well, for example, with me once it was a flood in the evening, it was after supper, and he actually phoned down and said, you know, there is a flood, the walls are wet. And I said, oh, I'll come up and have a look. So, I went up and had… I spent about 15 minutes with him and when I got there he said, I can't remember why you came. And I said, because you mentioned that there might have been a leak somewhere. And he said, no, I can't see one. I said, so that's sorted now, is it? And he was fine. But he just needed, sort of, ten, fifteen minutes to…

RE Yes. And if you'd have said on the phone, no, I'm sure there isn't, it's fine, go and ask someone on the floor…

SM Do you know what, I, yes, I wouldn't be able to do that.

RE No. No. But it…

SM I suppose that's just me. But I think if…

RE But that wouldn't have worked as well would it?

SM No, it wouldn't have worked and actually it would have made the staff up there, that would have been very, very difficult for them because then he would have… it would have escalated. I think it has to be a team work at all levels. Senior staff and junior staff have to be able to, sort of, work together, sort of, tag team each other at times, really.

RE Yes. And how did… because I was just thinking about how decisions get made then within the teams about, kind of, how to manage these things.

SM Oh, well, what we do is, we sort of do a little bit of a… and this is Community Mental Health Team actually have done this and it has worked, is that we get together and we say what sort of things, what do you think the triggers… so, we'll keep a behavioural chart for two or three weeks and see, and try and work out… And, sort of, the staff that tend to work in that area because we are using agency and we have them moving all over the place which is not ideal for dementia patients either or for the staff for that matter. But then what we do is we will do out a little, I don't know, a little information sheet I suppose really, you know, that, you know, this is Doctor So and So and I become, I can become agitated and I may well talk about blah, blah, blah, blah, blah, blah, blah, but if I can be distracted by… and, again, we, sort of, put things down. So that it's just like a one sheet thing, it's like a little crib sheet and we make sure that all of the staff then who go up there read that.

RE Yes.

SM We have three people up there who have challenging behavioural problems like that and they've each got a little thing so that they don't feel… and we also say to staff, if you think it's escalating, getting out of hand, call the senior staff, we'll come, you know, because, you know, it may well be that, so I take 15 minutes off and bring him down and have a walk outside and then bring him back. Because they haven't got the time to do it at that particular point in time. I'm so sorry about this.

RE That's all right.

IE I'm really talking about teamwork more than anything else because I think one person cannot do it and I have noticed sometimes if one person is quite good with dementia clients or finds a sort of a rapport, then they're left to it and that doesn't work. That can only work for so long. So I think it has to be a team effort. There are people who naturally are better at relating to older people than others and there are some people who just aren't really that good at it and if you can't relate to older people then you're going to have problems with dementia because you're not going to really see it. I was lucky because I knew my great-grandparents and all my great-aunts and uncles and all and we all lived in the same area of xxx for over 300 years. And I used to ...

IV You are old.

IE No, the family. Yes, very old. And I was the first one to leave and go to university. So it was sort of ... I became quite exotic at that point. But that's when I realised other people don't have that sense of family at all or ... I didn't grow up with a fear of older people or old age.

IV Because lots of people I've spoken to have talked about there being kind of some people who are just kind of naturally better at it for whatever reason and then there's other staff who struggle more around people with dementia or older people. Do you think that it's something that can be taught? I mean do you ...

IE That's very interesting. I think yes, there are certain aspects that can be taught but actually if you don't have the underlying personality, if you don't have those traits of kindness and caring and compassion and the ability to see things from the other person's point of view. I would say anybody who can't do that shouldn't be in caring. That's all. But there are a lot of people who do a fairly decent job but they just don't have that connection.

IV And as a manager what do you ... how do you manage that? I mean how do you ...

IE I just fire them when they get ...

IV That's actually quite ... because it is a recruitment issue isn't it?

IE It is a recruitment issue and it has to do with being able to build relationships. People look upon caring like wiping bums and that's the bit that everybody sort of turns their noses up and says, well I couldn't do that. But in actual fact that's such a minor part. And when you've wiped a few bums you forget that you're wiping bums to be honest. The fact is you've got to be able to build a relationship both with other staff members and with the client themselves and with their families. So it's a multidimensional relationship. Some people can't cope with that. The people that cannot cope with it so well I tend to allocate them to folks who know what they want, know what they're doing, know where they want to go so that they can speak for themselves. It is an issue when it comes to your yearly appraisal in terms of you know, how well do you think you're doing? And I recognise that some people will, you may learnt sort of ideas or, you know push button A, push button B but you'll never be able to do it in any other order other than you've been told try this first, try that next. Yes, there's no flexibility with it. So I do think for dementia clients particularly they need someone who can. And it is empathise, not sympathise but empathised definitely. I also think that the people who can do that are probably people who know themselves better so they know when they're beginning to get stressed and not coping and they're the ones who will come and say, I really need five minutes, you know? And they won't get angry or upset about it. They'll just say, do you know what, I just need a cup of coffee now at this moment in time and then come back to it so rather than struggle on and end up going under.

IV And do you find that the ones that are maybe less kind of naturally attuned to doing it are the ones that don't stay as long or who leave or is it ... does it not work like that?

IE It's interesting. On the whole I find that those sort of people do ... yes, they don't tend to stick at it unless there's some other economic or other reasons for being in this particular job. Part of the issue for the company here is that we've had people on work permits and it's very difficult for them if they move from a work permit job to find another work permit job.

IV So what does that mean? Sorry, just say ...

IE So in other words they're stuck here until their work permit runs out which may three/five years. And there's not really very ... so unless they do something that's grossly negligent you can't really do very much with them apart from gives them the education, send them on the dementia training and self-awareness and that sort of stuff. But I find that when you send people who are unself-aware on a self-awareness course they come back even more unself-aware than they were when they went. Sometimes I think you either are or you aren't.

IV Yes. And are there other ... I mean just in terms of agitation, you mentioned the community mental health team. So what kind of things do they suggest, I mean or try? You know, is there a lot of ...

IE Well the crisis team will only come out in a crisis basically but if there are people who are having behavioural issues and the GP suggests it we refer them to the Memory Clinic, for example, and have a look at medications and things. They tend to come at it from a very doctorish point of view to be honest. But then if it ... initially. So they'll look at ... well they'll look at whether anything's organic first as they always do and if it can be pushed off onto the GP they'll do it. But ...

IV So things like pain or infection?

IE Things like pain and things like, yes, infections, underlying conditions, that sort of stuff. Once all of that is done, blood work and all that comes back and it is pretty sure that it's going to be a psychiatric issue then they'll look at medications first, then they'll look at bringing in a psychologist whereas sometimes it would be nicer if ... I understand in a crisis where somebody is at risk of harming themselves or harming someone else you have to do something pretty immediately. I mean that's usually pills until things settle. But actually the only way to get to stop, I really don't like the chemical cosh. It drives me ... and when I was training they used to give haloperidol like it was, you know just knock them out and left to dribble. And the amount of falls we had from that was just ridiculous and people just ... And so I'm kind of anti all of that so to speak. I do recognise that for some folks there is a need at that point but then it's how ... once we get the tablets working, how then do we change what we're doing. Because with dementia patients we're not going to change them. We need to understand them to be able to take the aggression down so that they don't become aggressive. You can't reason with a dementia client because, you know.

IV And do you think your staff kind of see it that way? I mean, I suppose, whose responsibility do they feel it is to kind of manage the agitation? Is it something that they would ...

IE I think we have always said if you get into trouble whether it be with somebody who is demented or not we are a team called the senior team. So there are always team leaders and above here. There's myself and a deputy and team leaders and there're always at least two, if not like today four, of us around so you can always call on one of us and we will come and have a look at what's going on. I mean it may well be that we turn around to you and say, so why did you call us? What was your issue here? Because if you're telling me you can't cope then we need to be looking at, you know. So it can backfire on them sometimes because you will find some people say, we're not dealing with this, we get a senior team up here. But they do that all of the time.

IV Yes, that's what I was wondering about is whether they say it's something they can actually handle themselves.

IE They know they can, it's only if they feel out of their depth that they're supposed to give us a ring but they're helping a couple of them who've pulled the wool a bit or tried to but then it comes back to them, you know, if you are in the process of washing or dressing someone and you can't get anywhere and you've called one of your team members to give you a little bit of a hand and you're still getting nowhere then I think that's fair enough to call us in but if you haven't even tried. Oh I'm not going to that one because he hits, I'd better get a senior team up here. That's when you ... So yes.

IV And what about activities and things? Is that something that everybody gets involved in or do you have ...

IE Our activities down here ... we have activity staff and we do have some of our own care staff who are covering the lounge, they're on lounge duty. That tends to be from about 10:00 in the morning through then for the rest of the day and in the afternoon. So people who are covering the lounge will then also take part in activities and sort of keep an eye so people needing toileting and that sort of stuff and needing assistance with cups of tea and things. So we try and have ... so we have in the mornings two activity staff, one volunteer, one activities co-ordinator and two members of staff downstairs. But you can at times have 30/35 people downstairs. It just depends, it really does. Sometimes it's a lot less. Yesterday morning I was quite surprised in the morning it was only about 20 so then we [unclear] didn't want to get out of bed. But other days you can have quite a ... the barbeque we had all 55 residents out. We had to take some of them in again but we did have all 55 out at least for a little bit which is a big success really.

IV But do you see activities and stuff as kind of helping with the more agitated behaviour as well? I mean is that ...

IE It depends how communicative they are because some of our folks, apart from saying hello to them and shaking their hand, yes, you can't get any communication with them at all. So even one-to-one working things it's quite difficult for them. And it's a matter of finding out the sort of things they enjoy so maybe that they enjoy a cup of tea and a biscuit. So that takes the edge off for them. Or they enjoy watching TV or listening to the radio and that takes the edge off for them. So it's finding what their likes and dislikes are. And one thing I've discovered with dementia patients is that

some of the families say, he's listening to Radio 4, he never listened but they do now - or Radio 3 actually is the big one. They go, Radio 3 really? We didn't have it on in the house. And they love it. So I mean I think sometimes even the families don't know what their likes and dislikes are. Sometimes it's trial and error.

IV And what about ... is there a difference with night stuff do you think in terms of kind of how agitation gets managed or how staff feel able to manage?

IE There is. I mean we have the same thing on. We have ... unfortunately we only have one senior team person on at night surprisingly.

IV Yes, you're not here every night?

IE No, I mean I've done a couple of nights, three I think in the last year. But they ... the night staff are a different breed to be honest. We don't do internal rotation here so people don't move through, they don't go from days to nights, to nights to day. Some of our staff do when holidays [unclear] and they'll do a set of nights but it's not regular. The night staff tend to be their own little team and there are ... there's only one person on nights who is not that sort of ... we're very luck actually ... is not that sort of compassionate, kind, motherly type; more on the efficient side of let's get things done. So they're never put on the dementia floor to look after people here ... it can be ... but they're very good actually and they support ... they're amazingly supportive of each other. I mean in fact if anything could teach us about team work it would be the night staff because they ... because there's one per floor basically plus a floater but if there are any issues they do support each other quite well. And during the day it's because there's more people they go, I'm not working on that floor. That drives me nuts. But I do understand that if you want to get something accomplished in a day and you're in an area being called away constantly to go to a different one because people aren't coping very well it's quite frustrating too. Yes.

IV And so do you ... do your staff move between you or do they tend to ...

IE Yes. They do move a lot actually. They're traditionally here ... they were never put in the same place twice it seemed like. The idea behind that I was told is that they should know all of the clients throughout the building. That's a nice idea but there are 62 people here. Are you kidding me? That's ... I mean it's all very well for me to get to know everybody but it's actually quite difficult for the staff and the key worker system just wasn't working because the key workers were never in the area they were supposed to be in. So we had a look at settling people into areas a little bit more and we tried that but it kind of fell through because we have vacancies and long-term sick and maternity leave. Women get pregnant. And so we would ... yes, we've had three pregnancies in the last year. That's an epidemic. And then we had to sort of keep moving and then we were using agency and using agency and using agency. We're very lucky because the agency guys that we've got tend to become permanent so we've been quite lucky so although we're using agencies it's only the occasional one that we don't know and they tended to build up relationships with ... Because I've offered them jobs but they don't want to tie themselves down to ... you know, they want to be able to take a day off when they want to take a day off; they don't want to tie themselves to a rota or anything like that so that's a bit sad. So we've been lucky that way but it does mean that if I have through agency then I'm

going to have to spread my staff so I don't have more than one agency on any floor. So now they're still moving around. One of the meetings this morning was all about that and it's about getting enough staff so we can actually start to do something. Because I think it is quite therapeutic. But what I would do is that we would ... the morning shift would be in an area so from half past seven until 4:00 the people would be in that area and the afternoon shift would change. Because one of the things that I have found, for example on the fourth floor if you put someone on a long day on the fourth floor they are knackered and I'm not sure if they'd be able to come in the next day. Sometimes even doing an early shift up there can be quite tiring because you've got 10 quite severely mentally disabled folks, you know, needing everything doing for them. So toileting, incontinence, feeding, moving, pressure care, the whole ... you know and that can be quite ... when you've got that and in the afternoon there're only two people there so it's five to one which doesn't sound bad until one person kicks off and then you've got nine to one with somebody on a one to one. That's not good.

IV No. So you're constantly having to balance those things aren't you?

IE Yes.

IV So in terms of ... I suppose the things that maybe make it easier for you and your staff to manage agitation, what helps do you think? You know, what makes it work better?

IE God, that's probably reiterating everything we said before really. It works better if the staff know the clients and it works better if the clients know the staff or at least recognise them. It works better if staff's attitude is less to do with getting the job done and more to do with making the client comfortable. And that's a definition that isn't really ... I don't think it's really made very clear but I do think it is an issue. I'm dying in here.

IV I've got you ... held you hostage. But that's ...

IE But only coffee I'm afraid. But yes, I think those things help. The other thing is getting information from families and getting to know families and getting ... I've been amazed at how many families do not know what their parents did in earlier life or how many brothers and sisters they had or never met their grandparents. That's kind of foreign to me but I realise that actually it's probably ... I'm probably the exception rather than anything else. So whereas I would be able to have told you about, for example, my great-grandparents, my last great-grandmother died when I was 16 so I would've been able to tell you about what she did and what my great-grandfather did and what all of their children did and where they went to and, you know, one went to the diamond mines in South Africa and all that sort of stuff; I know all that sort of stuff. They don't have ... and many were killed in the war, that sort of thing, they don't know anything about that. And then they actually say, well dad never talked about his earlier life so I don't know. They don't know where they were born. They don't know ... So sometimes information is quite difficult ...

IV So it's harder when you can't get to know the person?

IE Yes, to know the parents as they had been, you know?

IV Yes. Can I ... just before you got this you were saying about this kind of division between I suppose the tasks that people have to do and I suppose focusing more on kind of ...

IE I think, yes, I mean I think there's a bit of a confrontation and some people understand it and do it. So you know you've got to get things done, making the beds, keeping the place clean, tidying the wardrobes and all that sort of stuff and other people ... but still see the client, still looking out for the client, still caring but they're getting other things done at the same time. And I think there are those within the caring industry who just see it as getting the tasks done. They don't see it as their job.

IV But where does that come from do you think? Just ...

IE I think it comes from old-fashioned nursing. Task orientation. Because I think the care industry in their homes have been very quick to snap up any ex-nurses who haven't gone back in or lost their registration, they're very quick to snap them up because it's their experience. And I think we suffer a little bit, maybe a lot, from that sort of nursing background in care is that, you know these are your jobs, these are your tasks allocations, get them done. And the relationship with the patient definitely came way down the list somewhere. Whereas I think it needs to be reversed. I think your relationship with the client comes first while you do these other things. I'm not saying the other things aren't important, they are. I mean you want to keep the place nice, you want to keep it fresh, you want to have a good environment and things like that as well but the main emphasis of the job is not making ... I mean it is making sure there are clean sheets on the bed but that's not the main emphasis, the main emphasis is that you're engaging with your client and they've having some sort of quality of life during the day.

IV Yes. And do you think there's anything about I suppose the way homes are run that make it harder to move away from that. I mean it sounds like here you work very hard against that but ...

IE But yes, but we still struggle. I mean we do still struggle because environment is one of the big things and for visitors and stuff like that we'll go around and you will get, like we do from time-to-time we get somebody saying there's a terrible smell on the fourth floor, there's a terrible smell on the third floor, that corridor is ... And what normally has happened at that point is that someone has been incontinent and the domestic staff here are excellent, they're on top of it. I mean the last time I had a complaint about there being a smell, when I went up to the floor the person was ... the floor was already being shampooed; I hadn't even had to ask. So I think there is this perception of homes should never smell. Well unfortunately they do from time-to-time it's how you deal with it is the big issue not whether it continues to smell. So there ... I think people do judge homes on sight, smell, environment and all that sort of stuff.

IV And people ... are you talking about like relatives or ...

IE Relatives, visitors, yes. I just might switch it off, it's fine. So I think there is a pressure on staff to do all of that sort of stuff. Got seven missed calls; I didn't hear it ring before did you? Okay, fine.

IV And so do you think there's anything about ... you've talked a lot about particular qualities that staff have and things. Do you think that there's anything in terms of kind of how things are organised either within the home or within the kind of wider group of homes that actually makes it easier for staff to kind of manage that more ...

IE I do, yes. I mean yes of course, you know. Allocation is a big issue but I think also being approachable is a major issue. Much as I would like to think that I'm very approachable I'm not always because I do have budgets and God knows what and I have meetings and I've got to get this information for that so sometimes I'm not as approachable as I would like to be. But I think if you can foster within ... it's almost as if a mutual respect for senior staff for junior staff and junior staff for senior staff. If you can get that sort of mutual respect going so they can recognise maybe the pressures that each are under I think that makes a big difference. So there's a lot to do with team building and teamwork and if you don't get that right it can be a complete disaster. But that's true. That's pretty basic all of that.

IV Yes, but it's ... I mean I think ... but it's important isn't it?

IE But it's very important for dementia clients because any sort of break within staff or separation of how they're thinking or what they're ... that can become very confusing for dementia clients and for me.

IV Yes. And what about relatives and visitors and kind of families generally? Is there anything about that that kind of either makes it harder or makes it easier do you think for staff to kind of manage the ...

IE I think it's always more difficult when relatives and visitors are involved because they don't ... they have ... they mean well, they really mean well. They want the best for their friend or their relative and they will ... their perception of what is going on isn't always necessarily what is going on but they don't always want to listen to that. So you'll get people saying things like the home should never smell. I would qualify that by saying it shouldn't stay smelly, you know? It should be cleaned as soon ... as quickly as possible. It's actually quite difficult because although you know that they mean well you also know that sometimes what they're asking is absolutely impossible. You know, when someone is refusing their tablets and I had one of the sons saying, but he must take his tablets and I'm saying, well if you'd like to come in and try. That's not my job, you're paid to do that. Okay thank you and we are trying and it's not that we're not but we're just ... he's just not taking them so I'm letting you know. If you want to watch us try and persuade him, please feel free. So sometimes they get, you know ... well ... I mean what sort of a care place is it if they can't even give him his tablets? So sometimes I think the attitudes and ideas that people have ... And also people ... and I think one of the worst things that we suffered from recently is all the news in the press about senior abuse. We get ... elder abuse has become ... and people are looking ... I mean it's almost like they're looking for ...

they're determined to find it somewhere. And people do talk about abuse now really in the last few years more than I've ever heard people talking about before.

IV And is that ... what is that, families? Or is that staff who are talking about it or ...

IE It's families, it's visitors, it's everybody really. Everybody is talking about it so I think if they wanted to highlight elder abuse they've done that.

IV What impact have you seen on the staff then of all of that?

IE I think it's created an atmosphere of fear. People have become scared to try new things, scared to attempt. I think it's created a barrier between staff and clients because they just ... you know, they don't want to get ... they don't want the hassle. They don't want to get into trouble.

IV No. And I wonder if that connects with what you were saying about kind of just getting the job done and getting the tasks done?

IE Yes. It ruins the ... yes, and it also ruins the relationship as well. So I think ... I don't think we've had enough good examples of good care. Nobody's perfect, nowhere is perfect and if we're looking for perfection we're not going to find it this side of heaven I shouldn't think. Certainly not in the ... well, nowhere but certainly not in the care industry. But if you're looking for really good examples of very good care there are lots of them out there. You know, there's lots of very kind, compassionate, caring people doing a very good job and you don't hear about it. You never hear anything about it.

IV Yes, I think you're right and you're not the first person to have raised it.

IE I'm going to have a rant and I do apologise.

IV No, I mean, you know. I was just thinking about, you know if there's any other barriers really that you see that we haven't talked about. Anything that just makes it harder for people to ...

IE I think environment. Environment can be a barrier. I don't like our fourth floor. I know it's being repainted at the moment but it's being painted in very bland colours and I know it's supposed to look absolutely lovely but really for dementia clients we want a little bit of colour. They say they're going to do that with the artwork on the walls, fantastic, we'll see is my answer to that one but actually a splash of colour can really brighten things up. Because dementia clients like everybody are very sensitive to atmosphere so they can pick up on things like that so if you have something that's bright and cheerful it helps. I'm not talking about really busy or in your face but just bright and cheerful, not beige. That's not even beige is it? But anyway, you know whatever colour it's supposed to be but, you know let's get away from magnolia. Fine, that's one thing, environment is one thing. I think budget is another. Economics, it always comes down to economics in the end and how much can we afford? That brings in activities and equipment and all of that sort of stuff and I think that can be a barrier sometimes. It could be a bottomless pit for money mind

you, you do have to be sensible about what you want to spend But that also goes for when it comes down to economics is how many staff ... what is your staff ratio? And I don't think the government are hard enough when it comes to dementia clients. The sort of RCN staff ratio is for residential dementia clients is something like 10 to one. Are you kidding? Or eight to one.

IV So that's just ...

IE If I have one staff member with eight dementia clients and they're supposed to survive the day it just ... that doesn't make sense; that really doesn't make sense at all. So I think the staff attitude. There's client expectation as opposed to relatives expectation. Those can become huge barriers.

IV Is that when client and relative expectations don't fit or is that ...

IE It's actually when the ... it's more when the communication isn't happening so the relative is saying this is what my mum likes and this is what I want her to do and the client is saying yes to the daughter but then saying to us, no I'm not doing that. The stress that that causes with the staff can be hugely ... well, just awful.

IV It's about communication?

IE It's about communication but it's also about people ... yes, it sounds so ... about expectations and staff attitudes. Managing relatives' expectations is so much more difficult than managing clients' expectations and clients' expectations are hard enough. And I think the senior staff really could do ... we could do with learning some coping mechanisms about how to deal with insurmountable expectations.

IV Yes, and I think, you know at senior levels you're probably even ... your ... you maybe do more of that and you're probably more skilled but I think for some of the more junior staff ...

IE Whether we're more skilled, we do more of it but whether we're more skilled or not I don't know.

IV But your junior staff actually ... I mean are the ones who will be the sort of first to come on and they're the frontline aren't they?

IE Yes, this is it, they're on the ... yes, they're right down there.

IV With relatives. And do you think that it causes them stress kind of managing those relationships?

IE We're lucky here. I mean I'm very lucky because the staff I have here are absolutely excellent. I don't ... I've had one complaint about a staff member being impolite; disrespectful I think the word was because they had addressed their mother by the first name. But you see people are still aware of the abuse in nursing because, you know how dare you call my mother xxx? She's Mrs xxx or whatever, you know? You don't ... and you just think, seriously, that's what you're complaining to me about? That's the only thing you've got to complain to me about? And I would say,

well I'll speak to the staff member and I'll have a chat to your mum but if you mum says, call me xxx we will go with what your mum wants and I always emphasise what client wants is what we'll go with.

IV Yes. But it must be quite disheartening for staff when things like that happen?

IE It is, it's demoralising and they sometimes feel that they can't do right for doing wrong. But the fact is the success comes when the client is happy, you know? Unfortunately it's not always the client who's filling in the satisfaction questionnaire at the end of it.

IV And how do you kind of ... how do you see agitation and, you know when people are more difficult to manage, what effect do you see that having on your staff, what impact?

IE I think mentally it's very draining. The one thing that we try not to do here is people being agitated as being labelled as challenging or agitated. We never use the word agitation. I try to avoid the word challenging as well because the challenge is not the client; the challenge is ours. So I've ... if someone is resistant to care or someone is becoming upset is what we tend to talk about or I tend to talk about it anyway, if someone is becoming upset then we try and ... certainly the senior team and we all try to encourage people to find out why. We'll ask the question what was happening at the time? What was going on? Do you think there's a reason for it? And actually I find that with a lot of our staff they will ... they won't just sit down and go, I have no idea. Some will but quite a number of them will go, well I'm not sure but I think they just had a visit from their family that hadn't gone well or something that we wouldn't necessarily have found out about from the client or from anybody else. So I think that's part of the teamworking thing is that you can throw ideas out even if they're not ... I mean none of the staff have actually said, I'm not dealing with this client anymore which is a good sign because as soon as they said that I would immediately think that you're not suitable for this job.

IV But do you see having a kind of ... do you see people becoming stressed or kind of burn out or ...

IE Yes, I do. I do see people becoming quite stressed about it and becoming quite ... burnt out is probably good word but weary mentally. It can actually mentally shut down so although you're not labelling someone verbally you've already done it mentally, you know? We always say if someone has an issue with personal care that we take two people with us. We try distraction, make sure that we try communicate with the client that they know what you're going to do, that you're going to wash them. We try to keep them as covered as possible so, you know lots of towels. They've got no, you know ... three or four towels if you want to. One over the shoulders, one around the waist, whatever, you know just keep them covered as much as possible. Things like that. So we try and get them to think themselves of ways to do it that will make it more acceptable for the client. Because I've always said to them if you came into my office or came into my bedroom at home and just started to undo my belt and take my trousers off I would wonder what the hell you were doing. So I may well hit out. So if you haven't communicated. But I do think that the education is great. All of our staff members here apart from the latest ones, the three

who have joined this year, they've all done dementia courses and it's made absolutely no difference to their work.

IV So tell me more about that. I think, you know that's what we're interested in. What ...

IE What actually works in practice?

IV What works in training as well, like what is helpful and what isn't helpful and why hasn't it made a difference to their work?

IE I'm ... that's a very good question. I mean I think some people see study days as a bit of a oh great a day off work.

IV Yes, do they go somewhere else to have training or do they have it here?

IE No, we often have them here. I mean we're doing completely different ones now. We're starting on the E training things and so all of their training records will be here but it's a separate company and they'll be marked by a separate company and blah, blah, blah. But they will be doing ... we will have small group studies on each subject at various points throughout the year and then people get their work book filled in from the information that they got and then drafts marked then they do an exam in it and that sort of ... yes, so it's a good system. It works quite well except for the practical subjects. So you can do the theory of manual handling but then you've still got to do the practical. So ... and I think it's the practical bit that ... what I really wanted to do with the education here is and the reason why I've suggested small study groups of five or six is that they're not on their own and they're doing it and hopefully there'll be enough people in that small group that will motivate some sort of learning so when they've got their work books they're not going home with them and just writing out parts and learning nothing and bringing it in and getting it marked correct the whole time but they're actually discussing things with each other and going through. Why doesn't it make a difference when they come back to work? I think because there are ... it does for some members of staff. It does, I can hear them saying, you know I was at study day and this isn't the right way to do this. So that's quite good, when you hear things like that. You think, oh. But there are those who just never talk about the study days at all. So we have been thinking that if people do go on study days outside that they should come back and sort of ... the next handover and give us a sort of five minute/10 minute catch-up on the day so if they know they're going to have to feed something back about it that they're ... it's something quite simple like what was ... name two things that you learned from the study day. That sort of ...

IV We're nearly done.

RE But, I mean, this thing about training, so, getting people to come and feed back and…

SM It doesn't have to be something really… yes, I, if you make it something really, really complicated people are just going to panic about it and think, oh my

God, I've got a presentation to do. It has to be something a little bit more relaxed and laid back and that, but there has to… you've got to, sort of, pick up something from it. I mean, I went to the study day on the new CQC inspection process and I came back thinking, oh my God, we'd fail, because it was, there was so much information and so much thrown at you in one day that really, at the end of it, I just, sort of, felt, there's no way we're going to get through all of this because this is just completely different to anything, any way we've ever done it before. So, I do understand when people go to a study day and think, God, I don't understand anything about this. But it would be nice for them to be able to come back and say, well, I went to that study day, I didn't understand anything, I'm not sure I got anything out of it. Because then you would know, well, actually maybe that's not the level that that person needs to be at. So, I think it can be negative and positive. But it's just the ability to be able to feed something back. But if you go to a study day thinking, I'm going to have to do a presentation on this, then you're spending more time worrying about your presentation than you are about absorbing the information.

RE Yes. And also if you just have a one off study day and you never come back to that.

SM Yes.

RE If it's… do you think it works better if there is a, kind of, I suppose, a course or something where you do less but more often, or…?

SM No. I think one off study days are great if it's actually something that you do at work every day.

RE Yes, if you're putting it into practice.

SM So, like, manual handling, for example. Yes. Nutrition. The MUST scores, the malnutrition things. We fill those, we fill those in every month. Pressure sores waterlow scores, things like that that we're doing all the time. If you can actually see it in your workplace then that's great. I think the ones that don't work are the ones that people aren't necessarily using.

RE Yes.

SM Or don't see how to use it in the workplace. We tend not to, you know, we are all quite practical courses really that we tend to do anyway.

RE Yes. But I suppose if it's around things like how to manage behaviours or how to, kind of, work with people when they're distressed…

SM Yes. And they do do that here. So, yes, but I mean, I think there will still be people who say, oh, I don't do that well, and cop out. I don't know how you get those in.

RE But do you think that there's anything you can do to, kind of, make it fit better for people or make it seem relevant or…?

SM Well, I mean, I think the key to it is that relationship. Knowing your client well and then knowing you. And anything you can do to increase that is really good.

RE Yes. So, building that into whatever…

SM Yes.

RE Yes. It would be. And just before I let you go, I've got you here, you mentioned earlier as well that language, that over half your staff would not have English as their first language or… You know, does that ever come up as an issue? Are there any issues related to that ?

SM Well, the issues are usually written, to be honest. Because if someone's talking to your face and you don't understand you can go, I'm sorry? I didn't get that. And I'm lucky because I have such a mix mash of an accent anyway, so, I mean, although I might look perfectly English, I don't sound it.

RE People still don't understand you.

SM Yes. So, that's quite good because then if people say to me, I'm sorry? Then I feel quite happy saying, I'm sorry, I don't know what you say about anything. So, it's not so bad face to face, I mean, our issues with that are written. There are two issues with the written side. One, we don't use trained nurses although some of our folks are ex-nurses. But those who have not had a nursing background and are asked to write a daily evaluation… I'm a great believer, I don't know if you've heard of SOAP.

RE Yes.

SM Yes. I like that because it gives you a skeleton to put something on. They don't want anything subjective in there at all, really. But it gives you something so people can look at subjective/objective evaluation and plan, that sort of thing, or whatever it is, activity and plan, yes. So, they, so, it gives you something to put, rather than just washed and dressed. And we're trying to get people to put more information in so, were they independent with their wash and dress? Was it one person that helped them? Was it two people that helped them? Was it just the back and bottom that they were helped with? All of that sort of stuff trying to get people… and the one thing that I cannot get people to stop doing here is write down, she seemed fine.

RE Yes.

SM To who? To you? To me? You know, what does that mean, fine, you know? It's like calling someone nice, it just doesn't really mean anything.

RE Yes. So, one thing is about the written.

SM So, one thing is about written and how they write things down. Because they will verbally hand over Mrs. Smith had a good night, Mrs. Smith is fine. And we're trying to get them to stop verbalising that and actually start…

RE And are there any other issues, like, in terms of the, sort of, how people are with residents or any, sort of, communication issues that come up?

SM Yes, there are some communication issues. Some of the… we have a lady here called xxx who I absolutely adore; she's such a character, oh boy. Everybody despairs of her at some point or another. She's the one who'll comment on my ties. And she actually said to me one day, do you go out dressed like that? Absolutely fantastic. But she will say to people, to their faces, it's just her type of dementia really, is, I do not understand what you're saying. And that can get them quite frustrated. Because they think they're speaking English really quite well. But at that point you just swap over to somebody… we always say to people, if someone doesn't understand you, stop boring, move over and let somebody else, go with somebody else and say, she's not understanding what I'm saying, can you have a go? And I've actually done that with some of the folks here as well when they've not been wanting to talk to me, you know.

RE Yes. And there's lots of reasons why people don't want to talk, isn't there?

SM Well, it's mostly because they think I'm the doctor.

RE Yes. It's because you've got a tie on.

SM Really? Other people wear ties. I could be a bank manager.

RE Yes. I mean, is there… we should, we should stop, but is there anything else that you think it's important to say about, kind of, how things… how agitation gets managed, about how to, kind of, get staff involved in that process, and…?

SM I think you have to, sort of, teach staff not to panic. If someone becomes violent verbally or physically, you have to be able to have staff… I mean, we teach staff here to back off, keep them within your sights, let somebody else know so you're not on your own, let somebody else know and we'll come up and deal with it. We've always said to staff try and de-escalate the situation. So, if it's because somebody is getting annoyed because of the noise that's going on or the music that's playing then try and bring them out of it. So, get them out of the situation. So, there are certain things you can teach staff to do but you can never teach them the attitude to do it in. So, some staff are very good at it because they've got the right attitude and other staff are very bad at it and say, I can't do this. And it's not… it's just a personality thing, you know.

RE Yes. Okay.

SM I suppose that has to do with recruitment doesn't it, really?

RE Yes, well…

SM Getting the right people in the right places.

RE It's not always easy is it, though? But thank you.