MDS – latest research

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Reviewing the RNCC tool, flexible skills mix, and the specialist nurse project

Chrysa Apps, Phillip Borkett, Margaret Cook, Peter Cox, Val Ellis, Jan Gilbert, Jan Reed and Bill Watson

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PART I

The Registered Nursing Care Contribution tool
An evaluation of use

Jan Reed, Bill Watson and Margaret Cook

1 Summary

- The Registered Nursing Care Contribution (RNCC) tool was introduced in 2001 to determine the amount of NHS-funded registered nursing care that residents in care homes need.
- This study evaluated the initial implementation of the RNCC tool by comparing it to the results of evaluation using the Minimum Data Set (MDS) tool.
- 186 care home residents were assessed and allocated to an RNCC band both by nurse raters and by the MDS RUG-III tool.
- RNCC assessment was carried out by five different raters: the care home staff, an external care home expert, the nurse researcher, a nursing consultant in the care of older people (a sub-set of the sample) and the official RNCC rater (where available).
- Both the MDS RUG-III and nurse assessment placed the majority of residents in the medium band. All of the nurse raters placed substantially fewer residents in the high band compared with the MDS RUG-III allocation.
- The level of agreement between assessments was calculated both as a percentage of agreement, expressing the number of times the raters agree relative to the total number of assessments made, and as the strength of agreement, measured using Cohen's Kappa coefficient.
- The percentage and strength of agreement between the MDS RUG-III and the nurse raters were generally low.
- There was a relationship between the knowledge base of the nurse rater and their level of agreement with MDS RUG-III. Those nurse raters with knowledge and experience of the context of care, i.e. the care home staff and the external care home expert, had a higher level of agreement with MDS RUG-III than did those nurse raters with more general knowledge of care for older people.
- The percentage and strength of agreement between the five nurse raters were low.
- The variability across nurse raters was lower, and therefore agreement was higher overall, for people with greater than median age. Neither the respondent's gender nor the number of recorded medical conditions had a statistically significant consistent effect on agreement between raters.
- The study found that the level of agreement between raters' RNCC allocations was not associated with the resulting degree of financial agreement.
- The care home staff reported difficulty in some cases in discriminating between the low and medium bands, with some residents apparently falling somewhere between the two bands. They did not report any problems assigning residents between the medium and the high bands.
- Experience of the care home environment would seem to be essential if assessments are to reflect the type and amount of care given in this specialised setting. The study suggests, then, that RNCC raters should have some experience of working in this environment.
- Differences between raters may have many different explanations, not least because of the unstructured nature of the RNCC tool itself. With multiple factors in play it is likely that there will be variations between raters, but it must be remembered that any rater who is different is as likely to be more as less accurate in determinations. Difference per se is not necessarily an indicator of inaccuracy, and without a benchmark to work to evaluating raters according to difference from others is not a valid process. Developing such benchmarks is necessary if monitoring is to be effective.

- This study took place at an early point in the implementation of the RNCC tool. As such, its findings form the basis for a larger study with a more diverse group of care homes. A larger and later study would be able to explore issues about gender, age and disability to a greater degree, and also to collect more data on official bandings.

2 Introduction

This report presents the findings from a study undertaken by the Centre for Care of Older People at Northumbria University to investigate the use of the Registered Nursing Care Contribution (RNCC) tool introduced by the government in October 2001. This tool was designed to assist in calculating the type and amount of care residents of care homes required from a registered nurse. From this determination, or banding into a high, medium or low RNCC category, the cost of registered nursing care to be paid for by the NHS would be calculated. The RNCC tool is an attempt to address some of the anomalies of funding and provision which have arisen in the care home sector through its long and complex history, and this report makes a contribution to these efforts in the way that it can inform the evaluation and development of the RNCC tool.

3 Background

The care home sector has a long and chequered history, with many forms of provision and many different management frameworks. Historians of the care home have variously traced its antecedents back to medieval monasteries, Elizabethan workhouses, Second World War evacuation policies and pre-NHS maternity homes (Means and Smith, 1985). These different histories mean that, while provision may have changed in response to changing societies, much of the current structure of provision bears the marks of former initiatives and developments. There are, however, some aspects of the care home sector which seem to be a constant matter for debate and dispute.

One such aspect is the debate about how to determine the type of care and support needed by older people in care homes. There is a concern to ensure that older people receive the right amount of care and support, with access to staff who have appropriate skills, in order that they can maintain quality of life and independence. This concern also exists against a backdrop of other issues, such as the ways in which care will be managed and resourced in a mixed economy of welfare provision, where some people will fund their own care but others may need state help with finance. The provision of care also reflects a mixed economy of welfare, in that some care homes are privately run for profit, others are run by voluntary sector not-for-profit agencies, and others are run by the state (i.e. local authority homes).

The situation is made more complex by the organisation of care home provision, which is made up of two types of facility, each with different structures and histories. One type of provision has been the residential care home for those who were thought to need social support and assistance with daily living. Local authorities were central in providing residential care until relatively recently, and entry into them was sometimes simply a matter of being eligible for housing benefit rather than because of any assessed need (Richards, 1996). Since the 1990 NHS Community Care Act, this situation has changed somewhat, with new residents who are not funding their own care having their care needs assessed and a care plan developed by their care manager (from the social services department concerned). Alongside this needs assessment was an assessment of ability to contribute towards the cost of care, with capital, savings and property being taken into account and any shortfall being taken up by the local authority. Residential homes were inspected and registered by social services departments who would stipulate

standards and procedures which the homes had to comply with. Because of this dual responsibility, for regulating residential care homes and funding places in them, local authorities have developed contracting or commissioning processes, whereby residential homes entered into a contract with local authorities to meet certain standards at specified costs. While this went some way towards guaranteeing standards and levels of provision within budgets, it meant that individuals could potentially be restricted in their choice of home to one that had a contract with the local authority.

The local authority has also had the responsibility of supporting people receiving nursing care in the other form of care home – the nursing home. Again there would be an assessment of need and ability to contribute towards the cost of care for those who were not self-funding, and this is where some of the anomalies became most evident. The issue of assessment of nursing need by social services staff, who did not necessarily have healthcare experience, became increasing disputed, leading to strategies for carrying out more joint assessments with healthcare staff (Burgner, 1996). The problems were, however, compounded by the fact that health authorities regulated nursing homes, including having responsibility for inspection and registration, so staff employed by local authorities had little involvement in setting standards or procedures.

Recent changes and developments

The 1990 NHS and Community Care Act began to change this situation in some ways, as indicated above. Local authorities were required to establish care management processes, which would mean that individuals would be assessed to determine the type of support they needed, and a 'care package' would be created which would, for some, involve a move to care homes. The role of care manager, however, was a complex one, and one which raised many questions about the expertise needed to make these assessments (Stanley *et al*., 1999).

There was also an increased awareness that the residential care/nursing home split in care was not always in the best interest of residents. Residents often had to move if their needs changed, in order to comply with registration regulations. This disrupted many relationships and friendships and gave rise to the stress of relocation (Reed *et al*., 1998). More flexibility was introduced into the system with the creation of 'dual-registration' status for care homes, which meant that they could accommodate people with a range of needs. The precise mechanisms of registration and inspection, however, were complex, and resulted in the setting up of joint inspection units, involving health and social services staff, and more recently the National Care Standards Agency, to oversee the process (Department of Health, 2000a).

During the 1990s there was also a decrease in NHS hospital beds for those needing long-term or continuing care (Department of Health, 2000b). As NHS hospitals focused more on acute care, patients were often discharged to care homes for continuing care and rehabilitation, where they became liable to pay fees for care. This understandably caused some protest as the effects of the anomaly were more fully realised, for example where people had to sell their homes to pay for care which would have been provided free in an NHS hospital. This was a particular point raised by the Royal Commission on Long Term Care, which reported in 2000, and it was suggested that a distinction could be made between health and social care elements of care costs, although the Commission was divided on the practicalities and principles of doing this.

In an attempt to resolve this situation, the NHS Plan (Department of Health, 2000c) accepted that registered nursing care should be free of charge to the recipient in all settings, including care homes. Nursing care has been defined by the Health and Social Care Act 2001 as:

> *services provided by a registered nurse and involving either the provision of care or the planning, supervision or delegation of the provision of care, other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse.*

Clearly this statement is open to a range of interpretations, and does not constitute an unequivocal definition of nursing care. The differences between nursing or health care and social care have long been a subject of debate, with little agreement being arrived at. Dalley (2000), for example, has described the successive attempts to draw and redraw boundaries between health and social care, and pointed to the differences in definitions, professional ideologies, policies and systems which have made attempts to integrate care so difficult. Defining need, then, and drawing the line between nursing and social care is fraught with difficulties. The government has therefore developed two other initiatives to clarify and standardise the process of determining need for care and support, the single assessment process (SAP) and the Registered Nursing Care Contribution (RNCC) tool. These aim to ensure that older people receive the amount and type of care that they need, in a cost-effective way.

Single assessment process

The first initiative is the development of the single assessment process, where health and social care agencies are required to develop a co-ordinated system for assessment through four levels:

- contact assessment, including the collection of basic personal information
- overview assessment
- in-depth assessment
- comprehensive old-age assessment.

This process is still in its early implementation phase, having commenced in April 2002 with local agencies determining their own procedures and processes. The Department of Health did not specify an assessment tool, but encouraged local agencies to build on current practice and negotiate a process and mechanisms that were acceptable to everyone. A list of criteria which processes should meet was given in the guidelines for implementation published by the Department of Health (2001a), along with an indication of the implications for the agencies and staff who would be involved. This could include GP surgeries, hospitals, community care services and drop-in centres, to name but a few of the varied agencies that might be involved in the assessment of older people. The intention is that assessments should be co-ordinated and communicated between agencies to avoid duplication and to ensure effective referral and response systems. In the words of the guidance document:

> *the single assessment process should ensure that the scale and depth of assessment is kept in proportion to older people's needs, agencies do not duplicate each other's assessments, and professionals contribute to assessments in the most effective way. The single assessment process also provides information to support the determination of the Registered Nursing Care Contribution for residents in care homes which provide nursing care.*
> (Department of Health, 2001a, p. 1)

The significance of the single assessment process for this study is therefore twofold. It indicates the general policy move towards integration of health and social services, and the increasing sharing of information which provides the backdrop for the RNCC development. Second, it indicates that the process will be linked to RNCC determination in that the information collected will be used as part of the RNCC determination process.

Registered Nursing Care Contribution (RNCC) determination

The second initiative is the development of the RNCC tool, to be used to assess the amount of nursing care that an older person needs and which the NHS will fund. This was launched on 1 October 2001 and was used to assess the level of nursing care that individuals need for the purposes of determining the fees that will be paid by the NHS to care homes, rather than by the older people themselves. This was extended to include reimbursement to local authorities in April 2002. The draft supplementary guidance on NHS-funded nursing care, published by the Department of Health on 20 December 2002, states that the reason for the introduction of NHS-funded nursing care for people in care homes providing nursing care 'was to ensure that this group of people had access to National Health Service funding and services on the same basis as others receiving NHS nursing care in other settings, either at home or in residential accommodation'. It points out that this also includes equipment and continence services, and that these new processes of funding also give the NHS 'a stake in commissioning services for this group of people'. In accordance with this interest, lead nurses in Primary Care Trusts (PCTs) are required to audit the outcomes and use of the RNCC tool, and to ensure that there are a 'sufficient number and range of nurses trained in the use of the RNCC tool within the Trust' (Department of Health, 2002, p. 1).

The RNCC tool is supported by a practice guide and workbook, which describes the process that raters should go through to arrive at an RNCC determination (Department of Health, 2001b). It is anticipated that for new residents, the application of the RNCC tool will have been preceded by a joint assessment, under the auspices of the single assessment process, so indications for nursing care need should have already been established and recorded in the care plan. This care plan should incorporate all types of assessment, including specialist assessments, and provide information 'indicating the intensity, instability, predictability and complexity of problems' (Department of Health, 2001b, section 2.9). From the information in the care plan, the RNCC determination can be applied – 'The RNCC draws heavily on all assessment information to determine the most appropriate level of registered nursing input' (section 2.11). In addition, the nurse undertaking the determination will use 'professional knowledge and observations of the patient in reaching a decision' (section 2.14). The guidance also goes on to say that this should be an individualised process, and not 'a bureaucratic paper exercise', and that the more familiar the nurse is with the patient, 'the easier it is to accurately determine individual needs for registered nursing care' (section 2.14).

Using the RNCC tool, people are allocated into one of three Registered Nursing Care Contribution 'bands': low, medium or high. They are defined as shown in the box.

The High Band

People with high needs for registered nursing care will have complex needs that require frequent mechanical, technical and/or therapeutic interventions. They will need frequent intervention and re-assessment by a registered nurse throughout a 24 hour period, and their physical/mental health state will be unstable and/or unpredictable.

The Medium Band

People whose needs for registered nursing care are judged to be in the medium banding may have multiple care needs. They will require the intervention of a registered nurse on at least a daily basis, and may need access to a nurse at any time. However, their condition (including physical, behavioural and psychosocial needs) is stable and predictable, and likely to remain so if treatment and care regimes continue.

continued overleaf

The Low Band
The low band of need for nursing care will apply to people *who are self-funding* whose care needs can be met with minimal registered nurse input. Assessment will indicate that their needs could normally be met in another setting (such as at home or in a care home that does not provide nursing care, with support from the district nurse), but they have chosen to place themselves in a nursing home. (Department of Health, 2001b, sections 3.8–3.10; italics in original)

The allocation of a person into the bands is determined by two factors:

- the type of care the person needs – i.e. whether a registered nurse needs to deliver some or all of the care
- the requirement for monitoring and overview – i.e. the extent to which the person's condition is stable and predictable.

People who need substantial registered nursing input and whose condition is unstable and requires constant monitoring and rapid response are therefore placed in the high band of nursing care, while those who are more stable are placed in lower bands. The lowest banding indicates people who do not need to be in a care home which provides nursing care – that is, community nurses could provide their nursing needs in the same way that they provide for people living in their own homes or residential homes.

Implications for research
The RNCC, therefore, is not so much a needs assessment tool as a costing and workforce-planning tool. In order for it to do this job effectively and accurately it needs to have a sound basis and to be compatible with other tools which assess the level of support that an older person needs for other purposes, for example care planning or staff management. The use of three broad bands, for example, needs to be compatible with the categories developed by other tools that have gone through processes of validation. When it was introduced in 2001 it only covered those care home residents who were self-funding (42,000 came into this category in the first year). It has been expanded, and from April 2003 the RNCC determination will be applied to all other care home residents (Department of Health, 2002, p. 1).

At the end of the inception period, then, it is timely to explore the progress of the RNCC tool. The audit data collected by lead nurses will detail the number of determinations made, the appeals against determinations that have been made and the final banding agreed on. It has also been suggested that lead nurses collect data on the determinations made by each individual rater and that a process of peer review and shared learning is set up (see the website created by the Department of Health: www.doh.gov.uk/jointunit/nhsfundednursingcare). It is not clear how and if this audit data will be shared or acted on, and this is included in a wider review of the RNCC process commissioned by the Department of Health. This study, then, has focused on the specific questions arising about the validity and reliability of the RNCC tool rather than issues about the processes of its implementation.

4 The study

This project was commissioned by the Joseph Rowntree Foundation to explore the results of assessment obtained by the RNCC tool. The study was designed to do this by comparing RNCC results with those obtained by the Minimum Data Set (MDS) and the EASY-Care tools, developed for contact assessment. Both of these are established and well-validated tools, and so the rationale behind the study was that by comparing assessments resulting from the use of these

well-validated tools, the validity of the RNCC tool could be judged. There are of course other tools available that have undergone similar processes of validation, but MDS and EASY-Care offered the study some advantages. First, the MDS tool has had extensive internal validation, and has developed to provide, through the Resource Utilisation Groups (RUGs) element, parallels to the RNCC assessment. EASY-Care has a similar international development, and is designed for ease of use with minimum training – it can also be used as a self-assessment tool. For both tools the need for training, which was beyond the capacity of the study to provide, was obviated, for MDS by the possibility of accessing care homes already using the tool, and for EASY-Care because of its ease of use.

The validity of a tool is dependent on its ability to help the user to identify key phenomena and translate them into measures, scores or scales which are consistent and accurate. There are issues, then, about the use of tools, which involve consideration of the type and nature of the information that the user has to collect in order to complete an assessment – how observable, unambiguous, stable and relevant this is. There are also issues about the way in which the tool helps the user to arrive at consistent results, and different users to arrive at similar results – issues of reliability. The tool should allow the same user to reach similar conclusions each time the tool is used, and for different users to have agreement. If this does not happen, then the tool is nothing more than an impressionistic and variable indicator of whatever it claims to assess.

The process of checking the validity and reliability of tools, then, is a vital process, and often a lengthy one. Repeated studies are often needed to check the consistency and integrity of a tool under different circumstances and with different populations of raters and assessed. This study does not attempt to do this for the RNCC tool – resources and timescale would not allow this, so the strategy chosen was to run the RNCC tool alongside MDS and where possible EASY-Care, on the same population of residents, to provide an indication of the robustness of the tool. Because the RNCC tool could be used by a number of different individuals with different qualifications, RNCC gradings from a number of different individuals for the same residents were also collected. Because any variations in grading have potential financial implications, for the resident (if self-funding), the care home, and the health and social services, scores have also been translated into funding levels.

The Minimum Data Set (MDS)

The MDS was originally developed in the USA as a result of an understanding that accurate assessment is fundamental to identifying the care needs of older people so that high quality care can be planned and delivered. An example of an MDS assessment sheet is given in Appendix 1. The MDS collects the minimum amount of data necessary to be comprehensive and reliable. Possible problems and risk factors, collectively referred to as Resident Assessment Protocols (RAPs), are identified in the assessment. These signify current problems, the high risk of developing new problems or the need for rehabilitation. All individuals are different and have a diversity of requirements, however MDS groups people according to how much resource they require. These are known as Resource Utilisation Groups (RUGs). The RUG-III system groups individuals into 44 categories within seven hierarchical levels (reduced physical function; behavioural problems; impaired cognition; clinically complex; special care; extensive care; rehabilitation). If an individual qualifies for more than one group he or she is placed in the most resource-intensive one. Using the RUG-III categories the MDS software produces three categories: low, standard and enhanced nursing care. These equate to the RNCC bands. The reliability and validity of the RUG-III system have

been established in several international studies (Schneider *et al*., 1988; Ljunggren *et al*., 1992; Fries *et al*., 1994; Ikegami *et al*., 1994; Carpenter *et al*., 1995; Carrillo *et al*., 1996; Carpenter *et al*., 1997; Bjorkgren *et al*. 1999).

EASY-Care

EASY-Care was developed from an EU-funded study to support integrated assessment in health and social care needs of older people in Europe. It is currently used in 18 countries worldwide, and an example of the assessment form is given in Appendix 2. It is designed to give a broad picture of the older person's needs in order to assist the practitioners to improve the care they can provide for the older person. EASY-Care was developed to elicit the views of the older person during a consultation between them and a practitioner. Work on the validity and reliability of EASY-Care is extensive (http://www.shef.ac.uk/sisa/easycare/html/reference/refset.html), and it was one of the tools identified on the Department of Health's website as meeting all the criteria for the single assessment process. (See the website for details: http://www.doh.gov.uk/scg/sap/toolsandscales/toolsandscales260902.pdf.)

The project's intention was to include an EASY-Care assessment for all residents in the study in order to provide some indication of the correspondence of RNCC ratings with self-assessed need. Because EASY-Care relies on self-reporting, however, it proved difficult to recruit adequate numbers to the study to allow comparisons with the RNCC tool to be made. EASY-Care requires respondents to be able to participate in a discussion of their needs and the frailty of the sample was such that few residents were identified as being able to participate. The EASY-Care data collected in the study are therefore not included in the results of this study. The problems that we had in using EASY-Care, however, do have a bearing on this study in the way that they indicate the frailty of those in care homes who are in need of nursing care. With such a frail population, who may be unable to express and communicate need, careful observation and assessment become even more important.

Aims of the study

The aims of this study were therefore:

- to establish the strength of agreement between the RNCC bandings derived from MDS RUG-III assessments and those of a range of nurse raters for older adults receiving nursing care in a care home
- to establish the inter-rater reliability of the RNCC assessment tool when used by different nurse raters
- to explore the views of the raters regarding their experience of using the RNCC assessment tool.

Timescale

The study was carried out in 2002, with data collection beginning in February 2002 and ending in August 2002. As the previous discussion has indicated, this was early in the implementation of the RNCC tool, and only a few residents, who were self-funding, had had an official RNCC determination. While conducting the research at this early stage in development runs the risk of hitting 'teething' problems, it does have the benefit of identifying ways forward at an early stage of implementation.

Project design

The project was designed to explore how the RNCC assessments, completed by multiple nurse raters, compare with the three bandings derived from the MDS RUG-III (Figure 1). Multiple nurse raters were used in the study in order to cover the potential range and experience of raters who could be employed to carry out determinations. Each nurse rater brought a different clinical knowledge base to the project:

- The care home registered nurses (A) had both knowledge of the care home environment and in-depth knowledge of the residents' care needs.
- The nurse researcher (B) employed on the study possessed general nursing knowledge.
- The external care home expert (C) had knowledge of the care home environment but no detailed knowledge of the residents involved in the study.
- A nurse consultant (D) had expert knowledge of care of older people.
- Official RNCC (E) bandings were also collected on those residents who had undergone RNCC assessment but where the raters' knowledge background was unknown.

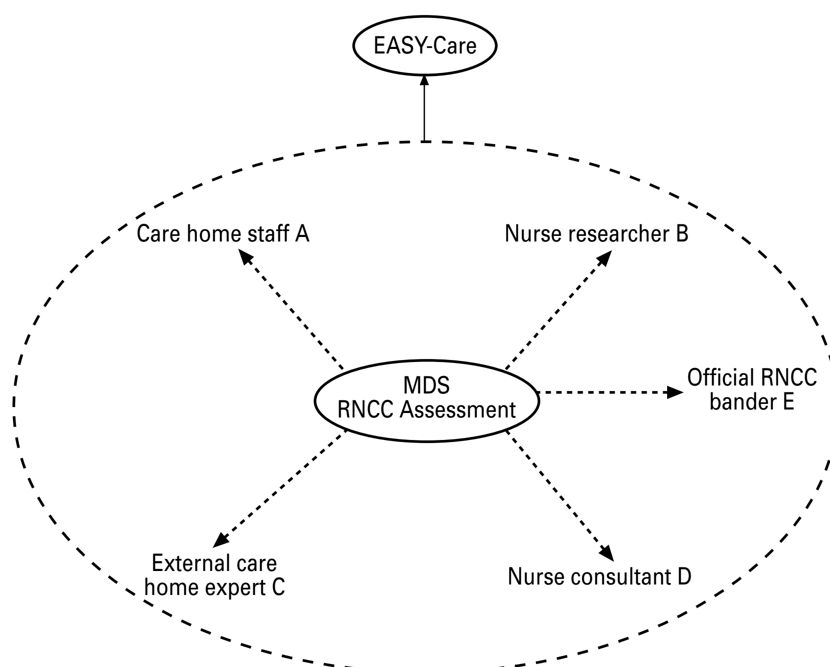
Raters B, C and D were single individuals, in order to minimise the impact of individual variations within each rater group, while the nurses in group A were a range of individuals with knowledge of the residents and the care home sector. Because of the way in which staff were allocated to residents in these homes, these were the nurses with most contact with the residents. Raters in group E were not identifiable in the study, and may have been a number of individuals. Each nurse rater with the exception of those in group E, for obvious reasons, was interviewed on the completion of the RNCC bandings to elicit their views regarding the RNCC tool.

Sampling

Because the study required homes which had already become familiar with MDS, the Joseph Rowntree Foundation was used to identify care homes using MDS software for inclusion in the study. Six care homes were recruited on the basis that:

- they provided care for a range of residents with differing physical and/or mental health needs
- they were competent in the use of the MDS assessment tool to assess their residents' nursing care needs
- they were willing to participate in the project.

Figure 1 Schematic diagram of the project design



Following the initial contact between each care home manager and the nurse researcher (Appendix 3), information and guidelines regarding the RNCC tool (Appendix 4) and the project (Appendix 5) were sent to inform the care home staff of the project. Negotiations between the researcher and the care home manager were conducted to establish the best method of informing each resident within the care home about the background of the project and to allow any resident the means of refusing to be part of the project. Different approaches were employed in different care homes, ranging from contacting the residents individually to supplying the necessary information and allowing the staff within the home to display and/or explain the project to the residents and/or their families (Appendix 6). Table 1 gives a brief description of each of the participating care homes in the study.

The overall total number of residents within the participating care homes in the study was 296 with a high proportion of nursing care residents (218: 73.6 per cent). The total number of residents classed as residential was 58 (19.8 per cent) with the remaining 20 (6.7 per cent) of residents identified as elderly mentally infirm (EMI). However, of the six care homes in the study only one had separate provision for the care of the EMI with the remaining five homes integrating these residents within their nursing and/or residential care beds depending upon each resident's care needs. Two of the six care homes in the study were managed by charitable organisations whilst the remaining four homes were privately owned by large care home organisations. The locations of the homes provided a geographical spread from the North East to the South West of England (Figure 2).

Residents' characteristics

The total number of care home residents in the project was 186 with a high proportion of females (142). Residents' age ranged from 54 to 102 years, with the majority (141: 76 per cent) of residents aged 80 years or more (see Table 2). Co-morbidity ranged from one lady having no reported illness to residents with ten reported illnesses. Many residents had illnesses covering as many as six different physiological systems, highlighting the complexity of the healthcare problems experienced by these residents.

Figure 2 Location of participating care homes

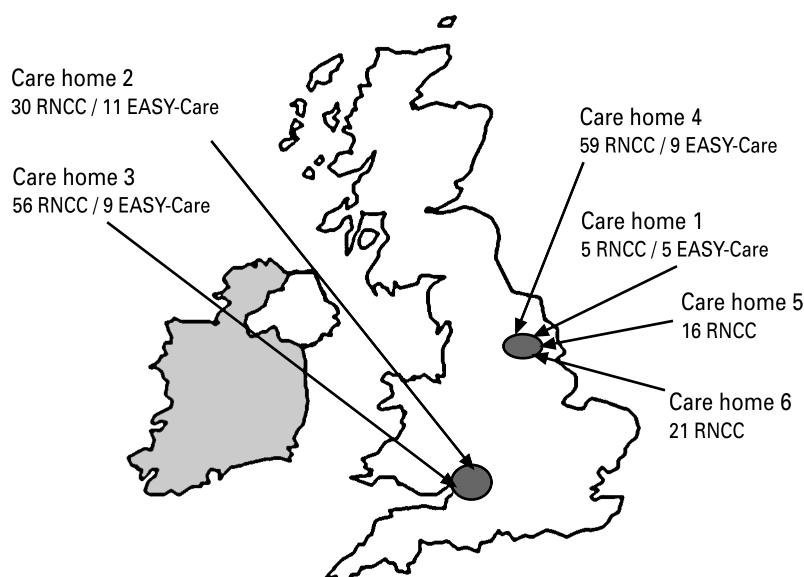


Table 1 Overview of participating care homes

Care home ID and brief description of setting	Total number of residents	Number of nursing care residents	Number of residential residents	Number of elderly mentally infirm residents (EMI)
1 Large purpose-built, continuing care retirement community managed by a charitable organisation, which includes a central care centre that is dual registered	41	14	27	
2 Large charitable organisation with a mixture of old and new purpose-built properties that are dual registered. Also has one 'intermediate care bed' and 7 respite beds plus 90 units of sheltered housing	61	54	7	
3 Large purpose-built 60-bedded care home, comprising 3 floors that are managed as single units. EMI residents are cared for in a single unit. The care home is part of a privately owned care home organisation	60	40		20
4 Large Jacobean hall converted to a care home. Part of a large privately owned organisation	67	64	3	
5 Small care home that is part of the private organisation which includes care home 4. Dual registered and can take EMI residents but they are not cared for in a separate unit and are counted in the nursing/residential residents depending upon their care needs	21	21		
6 Medium-sized purpose-built dual registered home, which is part of the private organisation that includes homes 4 and 5. Dual registered; can take EMI residents but again these residents are counted in nursing/residential residents depending upon their care needs	46	25	21	
	296	218	58	20

Table 2 Residents' characteristics

Number of residents	186
Gender	Male 44 (24%) Female 142 (76%)
Mean age (Range)	85 years (54–102 years)
Mean number of reported illnesses (Range)	3 (0–10)

Of the 186 residents, the majority (116: 62.4 per cent) were funded by their local authority whilst 69 (37.1 per cent) were self-funding. The NHS funded the remaining one resident.

Process

Registered nurses using the RNCC tool assessed 186 care home residents within their respective care homes according to the guidance criteria supplied with the RNCC tool (see Appendix 4).

Data were also extracted from care plans for each of the 186 residents with each data set including information on the following:

- personal details including age, gender, date of birth, past medical history, current condition
- nursing care plan
- nursing notes
- structured assessments such as pressure risk, nutrition, risk of falls and moving and handling
- current medication.

Each anonymised data set (see Appendix 7 for an example) was used by the nurse researcher (B), the external care home expert (C), and the nurse consultant (D) to allocate residents into RNCC bands. Official RNCC bandings (*n*=51) were also collected on those residents who had undergone RNCC assessments. The nurse consultant was only given a sub-set of 45 residents to assess, comprising random samples of 15 assessments taken from the MDS RUG-III low, medium and high bands. The total number of official RNCC assessments is low because of the period of the study, when only self-funding residents had RNCC assessments made. The official RNCC assessments were only available on those residents who had undergone assessment prior to or during the period of the project.

This produced a maximum of five RNCC assessments for each resident, which were compared with each other and with the rating obtained through the MDS software. Only the care home staff and the official RNCC raters had knowledge of the residents' identity. None of the data sets used by the researcher, the external care home expert and the nurse consultant contained any means of identifying any particular resident.

On completion of the RNCC assessments, all registered nurse raters were interviewed to explore their experiences and views on using the RNCC tool.

5 Results

The total assessments carried out by each rater and the categories of the assessment are given in Table 3 below. As can be seen from this table each rater placed the majority of residents in the medium band. The MDS RUG-III assessment placed 57.6 per cent of residents in the medium band. Proportionately, three of the other raters placed substantially more residents in this band (care home staff, external care home expert and official rater) whilst the researcher and the nurse consultant placed the same or slightly fewer residents in the medium band. Conversely, all of the nurse raters placed substantially fewer residents in the high band compared with the MDS RUG-III allocation.

This is also reflected in Table 4, which shows the percentage of agreement between MDS RUG-III and each nurse rater for each RNCC band. The percentage of agreement is markedly lower in the high band, compared with both the low or medium bands, for all raters except the nurse consultant, in whose case the agreement is equal across each RNCC band.

Level and strength of agreement between RNCC and MDS RUG-III

As stated earlier the RNCC banding derived from the MDS RUG-III was used as a benchmark to compare the RNCC assessments completed by the different nurse raters. Inter-rater reliability is an estimate of the degree to which two or more independent raters are consistent in their judgements. The assessment of inter-rater reliability is particularly important in the development of a standard measuring instrument which will be used by a variety of raters in a variety of situations. There are several methods of assessing inter-rater reliability. This project measured inter-rater reliability using two methods.

The level of agreement, using percentage of agreement, expresses reliability in terms of the number of times the raters agree relative to the total number of assessments made. Percentage of agreement is the most frequently used measure of inter-rater reliability and the most appropriate when there are few distinct categories. The overall percentage of agreement between the RNCC banding derived from MDS RUG-III assessments and those of the range of nurse raters ranged between a high of 60.66 per cent (external care home expert) and a low of 40 per cent (nurse consultant) (Table 5).

The strength of agreement was measured using Cohen's Kappa coefficient, which measures the proportion of scores which fall into the same category. Kappa can vary between 0 (no agreement) and 1 (perfect agreement). The strength ranged from poor agreement (0.1) between MDS and the nurse consultant to only a fair agreement (0.263) between MDS and the external care home expert.

Table 5 shows the agreement between the MDS RUG-III and each of the nurse raters' allocation of residents into RNCC bands in rank order, with both

Table 3 Number of residents allocated to each RNCC category by each rater

Assessments by	Low	Medium	High	Total
MDS RUG-III	31	106	47	184
Care home	26	123	37	186
Researcher	71	107	8	186
External care home expert	36	130	19	185
Nurse consultant	7	24	14	45
Official	10	36	5	51

Table 4 Percentage agreement between MDS RUG-III and each nurse rater for each RNCC band

	Low	Medium	High
Care home	54.84	71.70	27.66
External care home expert	64.52	78.30	17.39
Researcher	80.65	62.26	6.38
Nurse consultant	40.00	40.00	40.00
Official rater	71.43	78.57	6.25

Table 5 Rater pairs in order of strength of agreement

Rater 1	Rater 2	Kappa coefficient	Significance level	Overall % of agreement	Financial difference
MDS	Care home	0.218	0.001	57.61	£230.00
MDS	External care home expert	0.263	0.001	60.66	£1,295.00
MDS	Researcher	0.173	0.001	51.09	£2,965.00
MDS	Nurse consultant	0.100	0.315	40.00	–£240.00
MDS	Official rater	0.187	0.144	54.90	£545.00

Kappa coefficient and overall percentage of agreement plus the degree of financial difference. The external care home expert rater, who represented knowledge of the care home environment but no detailed knowledge of the residents involved in the study, achieved the highest level of agreement with the MDS RUG-III allocation. However, with a Kappa coefficient of 0.263 and an overall percentage of agreement of 60.66 per cent, this still represents only moderate agreement. The next highest agreement is with the care home staff. The two highest-ranking raters, therefore, share knowledge of the care home environment, whilst the lower-ranking raters did not possess such knowledge. In broad terms, however, there is little difference in the level of agreement between all the nurse raters, with four of the five achieving overall percentages of agreement within 10 per cent of one another.

The degree of financial equivalence between MDS RUG-III and each of the nurse raters is also shown in the above table. This indicates the difference between the financial consequences of the MDS RUG-III allocation of residents into RNCC bands compared with each of the nurse raters' allocation. For example, where the cost derived from the MDS RUG-III allocation is £13,675.00 (£35 for residents allocated into the low band, £70 for residents allocated into the medium band and £110 for residents allocated into the high band) and the cost derived from the care home staff's allocation is £13,445.00, the financial difference is £230.00. A negative figure indicates that the nurse rater's cost was higher than the MDS RUG-III cost. It is notable that the rank order of nurse raters in the table is different in relation to financial difference to that of level and strength of agreement. This indicates that there is poor correlation between the strength and level of agreement and the financial consequences. High agreement between raters does not lead to financial equivalence. It is likely that this is due to the funding structure of the RNCC tool and that financial equivalence stems more from agreement specifically in the high band than from overall agreement. As was noted above, the nurse raters were conservative in their allocation to the high band relative to MDS RUG-III.

Level and strength of agreement between the different nurse raters

Table 6 shows the strength and level of agreement and the financial difference between the nurse raters. The strongest agreement was between the nurse researcher and the external care home expert. However, with a Kappa of 0.437 and an overall level of agreement of 70.81 per cent this still represents only a moderate agreement. Interestingly, the two raters with the greatest degree of knowledge of the care home environment, the care home staff and the external care home expert, achieved an even lower strength of agreement. Again, as with Table 4, there is no association between the agreement among raters and the financial outcomes of the assessment.

Subgroup analysis

As shown above, there was poor to moderate agreement between the nurse raters overall. In order to understand this overall pattern in greater detail, analysis of the agreement, accounting for residents' age, gender and co-morbidity, was carried out. Measurement of co-morbidity was based upon the number of illnesses recorded within each resident's nursing notes and care plan.

Table 7 gives the agreement between MDS RUG-III and each nurse rater for males and females separately. The table shows that the gender of the resident has little overall impact on the strength and level of agreement between raters. There is not a substantial difference in the Kappa coefficient values for any rater pair across resident gender. The greatest difference is with the MDS RUG-III and external care home expert pair, where Kappa is marginally higher for men than for women, indicating that this pair agree slightly more for men than they do for women. However, even for this pair the difference does not change the overall magnitude of the agreement: it is still only moderate. It is a similar picture for the percentage of agreement values, with only one rater pair varying in their agreement with resident gender. The MDS RUG-III and care home pair had a considerably higher overall percentage of agreement when assessing female residents (63.12 per cent) compared to when they were assessing male residents (39.53 per cent).

Table 6 Nurse rater pairs in order of strength of agreement

Rater 1	Rater 2	Kappa coefficient	Significance level	Overall % of agreement	Financial difference
Care home	External care home expert	0.281	0.001	64.86	£1,070.00
Care home	Researcher	0.152	0.002	52.69	£2,735.00
Care home	Nurse consultant	0.218	0.032	53.33	–£495.00
Care home	Official rater	0.199	0.034	54.90	£435.00
External care home expert	Nurse consultant	0.348	0.001	60.00	–£565.00
External care home expert	Official rater	0.244	0.025	66.00	–£35.00
Researcher	External care home expert	0.437	0.001	70.81	–£1,665.00
Researcher	Nurse consultant	0.185	0.045	46.67	–£855.00

Table 7 Analysis by gender

		Male			Female		
Rater 1	Rater 2	Kappa coefficient	Significance level	Overall % of agreement	Kappa coefficient	Significance level	Overall % of agreement
MDS	Care home	0.029	0.799	39.53	0.029	0.799	63.12
MDS	External care home expert	0.378	0.001	62.79	0.210	0.001	60.00
MDS	Researcher	0.192	0.037	48.84	0.164	0.004	51.77
MDS	Nurse consultant	0.000	1.000	40.00	0.088	0.432	40.00
MDS	Official rater	0.000	1.000	57.14	0.243	0.023	54.05

Table 8 shows the agreement between MDS RUG-III and each nurse rater across resident age. The median age (85 years) was used as the cut-off point to create two groups: residents aged under the median point and residents aged over the median point. There was a little more variability in agreement across this factor compared with gender. For two of the rater pairs, MDS RUG-III with the researcher and the official rater, there was a change in the Kappa coefficient such that the strength of agreement was statistically significant for those over median age but not for those under median age. This indicates that, for these rater pairs, agreement was greater for older people than for younger people. Equally, for four of the five rater pairs their overall percentage of agreement was greater for older people that for younger people. MDS RUG-III with the nurse consultant was the exception to this, where there was only a marginal reduction in overall strength of agreement across increase in age.

Again, with the third factor, number of recorded medical conditions, there were some changes in agreement for specific rater pairs. Here, as with age, the number of conditions was split at the median value to create two groups: those residents with fewer than median conditions and those with greater than median conditions.

There was a change in the Kappa coefficient such as to affect the statistical significance of the strength of agreement for only two rater pairs: MDS RUG-III with the care home and with the official rater. For both of these rater pairs the strength of agreement was higher for those people with fewer recorded medical conditions. This was reflected in the change in the overall percentage of agreement (see Table 9).

Whilst there were differences in agreement between specific rater pairs for each of these three resident factors, it was difficult to see from this analysis whether they had a consistent or overall effect on agreement between raters. To test this

Table 8 Analysis by age

		Aged under 85 years			Aged 85 years and over		
Rater 1	Rater 2	Kappa coefficient	Significance level	Overall % of agreement	Kappa coefficient	Significance level	Overall % of agreement
MDS	Care home	0.105	0.247	50.63	0.270	0.099	62.86
MDS	External care home expert	0.058	0.471	49.37	0.402	0.082	69.23
MDS	Researcher	0.019	0.783	41.77	0.275	0.001	58.10
MDS	Nurse consultant	0.069	0.666	43.48	0.094	0.453	36.36
MDS	Official rater	0.057	0.661	51.85	0.335	0.014	58.33

Table 9 Analysis by number of recorded conditions

		3 or fewer illnesses			More than 3 illnesses		
Rater 1	Rater 2	Kappa coefficient	Significance level	Overall % of agreement	Kappa coefficient	Significance level	Overall % of agreement
MDS	Care home	0.303	0.001	63.87	0.076	0.394	46.15
MDS	Researcher	0.145	0.012	49.58	0.232	0.006	53.85
MDS	External care home expert	0.220	0.000	61.34	0.314	0.000	59.38
MDS	Nurse consultant	0.026	0.841	36.67	0.259	0.073	46.67
MDS	Official rater	0.306	0.013	66.67	0.022	0.880	38.10

further the variability in the difference between MDS RUG-III and each rater (*V*) was calculated using the following means:

$$V = \frac{(Rm - Rn)^2}{n}$$

where *Rm* is the MDS RUG-III classification, *Rn* is each nurse raters' classification, and *n* is the number of classifications in the data set.

This analysis showed that the variability across nurse raters was lower, and therefore agreement was higher overall, for people with greater than median age (t=2.25, d.f.=184, p=0.026). Neither the respondent's gender nor the number of recorded medical conditions had a statistically significant consistent effect on agreement between raters.

Analysis of raters' interviews

On completion of the RNCC assessment, 13 care home registered nurses and three external nurse raters were interviewed using semi-structured questions to elicit their views and experiences of using the RNCC tool. Using content analysis the data were classified in terms of recurrent issues arising from them.

Knowledge of the RNCC tool prior to commencement of the project

Responses ranged from no knowledge (three members of care home staff) to fully aware of the tool (nurse consultant with knowledge of care of older people). The external care home expert reported that they had asked their 'newly appointed care home manager about it and was told that it is to do with area manager and higher up'. They felt that this remark suggested it was not their place to know about it but they felt that this manager should have known more about the RNCC assessment. Remarks made by the nurses within the care homes participating in the study revealed that some had knowledge of the RNCC assessment tool whilst others stated they were totally unaware of it prior to the project. All the nurses reported it was the first time they had used the RNCC assessment tool and that they needed to read the instructions a number of times in order to understand the terminology, with one nurse stating that 'the terminology needs to be simplified'.

Raters' views regarding conducting the RNCC assessment

The care home staff continued to state that once they understood the terminology they felt it was easy to use especially as they knew the residents well. The raters whose assessment was based purely on the documentation had specific issues; all felt that it was difficult to complete the assessment without seeing the person because the documentation was limited. They had to rely upon their individual clinical expertise to mentally build up a picture of the resident's needs and reported that they relied upon the daily communication sheets for indications of whether the resident's nursing care needs were being met and to judge whether the resident's physical and mental state was stable/unstable and/or predicable/unpredictable. All three raters thought the care home's use of assessment scales such as pressure risk assessment and risk assessment scales assisted in building up the picture of the resident but that these did not necessarily indicate the person's care needs and were not always reflected in the resident's care plans. The external care home expert felt that the majority of residents within the majority of care home settings had stable and predictable care needs. The nurse researcher found completion of the RNCC assessment difficult at times mainly owing to the lack of knowledge regarding the difference between residential and nursing care homes. Questions such as 'do residential care homes have a registered nurse on duty?' and 'do residents in a residential setting undergo any formal assessment regarding any care needs?' were asked as ways of developing a better understanding of the care home sector.

Comments relating to contact with the official RNCC raters

The majority of the nurses within the residents' care homes reported that it should be easy for an 'outsider' to complete the RNCC assessment if the resident's care plan was kept up to date. However, they acknowledged that this was not always the case and some care plans were incomplete. It was also acknowledged that the official RNCC rater did have access to both the residents and the nurses involved in their care and did not have to rely solely upon what was documented.

The external care home expert stated that 'I have had no contact with an official RNCC rater within my care home'. The nurse consultant was fully aware of the background of the official RNCC raters within her clinical area and stated that 'their background is of experienced community nurses of G grade level with experience of the area's rapid response team'.

Identified problem areas

Nurses from the care homes reported difficulty in assigning some residents into the low and medium bands, with these residents apparently falling somewhere between the two. They did not report any problems assigning residents between the medium and the high bands. Some nurses felt that their experience of accompanying the official RNCC rater during their visits to the care home had helped them to complete the RNCC assessments for the project.

All three raters who relied upon the documentation to make the RNCC assessments reported that the main problems arose because of the variation of format and information within the residents' documentation. Some of the documentation was inadequate with some completing a variety of assessments but then identifying problems which were not reflected in the care plans. The raters also found it difficult because of their lack of contact with the resident being assessed. The nurse researcher had a problem with one data set which had large sections of information missing, making it impossible to build up a picture of the resident's nursing care needs, and in this case a 'guesstimate' was made as to the RNCC banding. The nurse researcher also noted a specific problem concerning those residents who suffered from cognitive problems and required a safe environment but who were self-caring regarding their activities of daily living. These residents may have required prompting and guiding with certain activities but there appeared to be no obvious need for a registered nurse other than for supervision.

The nurse consultant also felt the documentation was not wholly accurate but found the drugs charts a source of information which went further than informing which drugs were prescribed – for example, if the resident was prescribed skin preparations, pain relief, aperients etc., this indicated that they had some condition which required daily monitoring and therefore she placed them into the medium band rather than a low band. The nurse consultant was aware that she had not placed many residents into a low band. This was, she argued, due to the fact that whilst some residents did not appear to require the intervention of a registered nurse over 24 hours they had complex needs. If their care was carried out correctly then they wouldn't have any problems but if it wasn't then things could go very wrong and their condition could deteriorate markedly. These residents were therefore placed into the medium band instead of the low band. The nurse consultant also argued that residents with mental health problems were unpredictable and therefore she felt obliged to place them into the high band whereas in reality they may fit into the medium or low band with the right intervention. She also felt that older people suffering from dementia required care by a registered mental nurse.

Suggestions for the future
The majority of the nurses from the residents' care home felt that their in-depth knowledge of the individual resident's nursing needs was required to assess the resident's RNCC banding and that they should be the people doing the RNCC determinations. The staff also felt that the RNCC assessment did not take into account the amount of time they spent on other aspects of care such as care planning, training of healthcare workers, motivating and talking to depressed residents, to name a few. The nurse researcher acknowledged their lack of experience and knowledge of the care home environment and felt that it was important to understand the context of where the care was being delivered in order to place the resident into the appropriate band. The external care home expert believes that the official RNCC rater needs to be a nurse experienced in the care of the older person but did not feel that a community nursing background was a prerequisite. They continued to expand on this by saying 'it is entirely different nursing someone in a care home setting than just calling into someone's home for a short period of care'. The nurse consultant stated that the RNCC assessment is very flexible and in their opinion it needed to be so but they thought that a fourth band was needed, their suggestion being that the medium band be split into two.

6 Summary of findings

The agreement between the MDS RUG-III and the nurse raters' allocation to RNCC bands was low. Lack of agreement was particularly high for allocation to the RNCC high band, where, compared with the MDS RUG-III, nurse raters were conservative. Moreover, the lack of agreement was not uniform across all raters. In fact there were substantial variations between the raters' strength of agreement with MDS, and this difference may be related to the background and knowledge of the raters. Those raters with knowledge of the context of care appear to have a stronger agreement with MDS than those without this form of knowledge. An interesting finding is that the external care home expert's ratings had greater agreement with the MDS score than the resident's own care home staff's ratings, whilst those of the nurse consultant had the least agreement with MDS. This suggests that knowledge and understanding of the context of care is of greater relevance to the rating process than knowledge and understanding of older people, either in a personal or a general sense.

The findings, which show differences between raters' levels of agreement with MDS, indicate that agreement levels are not consistent, again suggesting problems with reliability. If differences were consistent across different raters, this could be interpreted as evidence that the MDS and RNCC would produce consistently different ratings, but the variation between raters indicates that this is more likely an indication that the RNCC tool itself is open to inconsistency. This lack of agreement was only partially explained by residents' characteristics, in that there was greater agreement for people with greater than median age, but gender or number of illnesses had no impact. On average, however, men were banded higher than women and younger people were banded higher than older people but the number of illnesses did not relate to the mean banding.

This study also found a low level of agreement between the nurse raters themselves, although the findings suggest that the nurse raters agree with one another slightly more strongly than they agree with MDS RUG-III bandings. This further suggests that the lack of agreement stems from the characteristics of the RNCC tool. Compared with the MDS, the RNCC tool is loosely structured. This allows for professional judgement and local and individual conditions to be reflected in determinations; however, it also allows more flexibility and therefore inconsistency in ratings.

7 Implications: the way forward for implementation

The study points to some important considerations which must be made when implementing the RNCC process, given that the tool seems prone to inconsistencies and variations between raters.

Resourcing RNCC raters

The raters who were interviewed felt that resident contact was important in completing an RNCC assessment. This was partly because of the variability of documentation and the standards of recording, but also because they felt that the knowledge built up over time would give a better picture of the resident – interestingly, some raters made use of the daily records to gain some understanding of residents' needs, rather than just assessment sheets. This suggests that RNCC banding may be a labour-intensive activity, if raters are to be able to spend enough time with residents. Some findings, however, suggest that spending time with the residents does not guarantee accurate assessment, e.g. the finding that care home raters were less in agreement with MDS ratings than the external care home expert.

Recruiting RNCC raters

As the study has shown, a nursing qualification on its own will not give results close to the MDS, even if the nurse has considerable expertise in the care of older people (for example, the nurse consultant in the study). Experience of the care home environment would seem to be essential if assessments are to reflect the type and amount of care given in this specialised setting. The study suggests that RNCC raters should have some experience of working in this environment.

Training of RNCC raters and the support and resources they will have, particularly the time they will have to access information

While access to the single assessment process results will help the RNCC assessment, this process is itself in an early developmental stage and may not provide enough reliable information to substantially aid RNCC determination. It is likely, then, that raters will have to access care home records and meet residents in order to arrive at a comprehensive understanding of their needs. This process will take time for each resident assessed, which may pose problems if too much emphasis is placed on speedy RNCC determinations. There may also be some implications for training for RNCC raters in the use of the tool, and the support mechanisms suggested by the guidance documents, including peer group discussions, may go some way to ensuring reliability. The content of training and the most appropriate delivery modes, however, is something which will need careful planning and evaluation as more is known about the issues facing RNCC raters.

Monitoring of assessments

The lead nurse has responsibility for recording and monitoring RNCC determinations and identifying any differences between raters. This study suggests, however, that differences between raters may have many different explanations, not least because of the unstructured nature of the RNCC tool itself. Background and experience also seem to affect determinations and so any monitoring will have to take this into account. With such factors in play, it is likely that there will be variations between raters, but it must be remembered that any rater who is different is as likely to be more as less accurate in determinations. Difference per se is not necessarily an indicator of inaccuracy, and without a benchmark to work to, evaluation of raters according to difference from others is not a valid process. Developing such benchmarks is necessary if monitoring is to be effective.

8 Implications for future research

The study was designed to capture the use of the RNCC tool at an early stage of implementation. As such it emphasised rapid data collection from specific settings, rather than a large study which may have been more inclusive but, because it would have been complex to carry out, would have failed to reflect the initial experiences and practices. Because of this focus, the study does not address later developments in the RNCC tool and, while it can give some early messages, does not follow developments over time. A longitudinal study is certainly worth carrying out to track the processes involved as raters, care homes, older people and their families become more used to the process.

The findings of the study could also form the basis for a larger study with a more diverse group of care homes. A larger and later study would be able to explore issues about gender, age and disability to a greater degree, and also to collect more data on official bandings. As this study took place at an early point of implementation, this was not possible as official banding was in its infancy and not fully operational in all of the areas for all residents. Evaluating official ratings against MDS and/or against other raters would indicate whether the RNCC tool in use was consistent and reliable.

There is also a need for more exploratory research about the experiences of those raters using the tool and the reactions of care home staff to this use. This study was able to collect some data on this, but the timing and scope of the study meant that this could only be indicative of some of the experiences and that issues could not be explored systematically or over time. Further work would be able to provide some insights into changing responses to the RNCC and the development of strategies and processes for RNCC determination.

9 Conclusion

The RNCC tool is an attempt to recognise and cost the nursing care input to people in care homes, and to ensure that this care, like other NHS provision, is free at the point of delivery. As such it represents an attempt to operationalise long-standing debates about differences between nursing and other forms of care, the role of the nurse and the needs of older people in a way that is user-friendly. These aims are laudable, but the process of achieving them is complex and it is to be expected that it would be difficult.

The aims of the RNCC tool are not simply theoretical, however, and it has potentially a significant impact on the way needs are assessed and care resourced. In particular this impact will be felt by care homes, whose provision needs to be resourced, and by health and social services whose budgets will be affected by RNCC determinations. It is important then, to develop the RNCC tool in such a way that everyone is comfortable with and confident about its use and application. This study, then, makes a contribution to this goal, by pointing out some of the lessons to be learned from the early days of implementation.

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Appendix 1: Example of an MDS assessment form

MINIMUM DATA SET - HOME CARE (MDS-HC)©

• *Unless otherwise noted, score for last 3 days*

• *Examples of exceptions include IADLs/Continence/Services/Treatments where status scored over last 7 days*

SECTION AA. NAME AND IDENTIFICATION NUMBERS

1.	NAME OF CLIENT	Melgers female b.1918 a. (Last/Family Name) b. (First Name) c. (Middle Initial)
2.	CASE RECORD NO.	
3.	GOVERNMENT PENSION AND HEALTH INSURANCE NUMBERS	a. Pension (Social Security) Number b. Health insurance number (or other comparable insurance number)

SECTION BB. PERSONAL ITEMS *(Complete at Intake Only)*

1.	GENDER	1. Male 2. Female	2
2.	BIRTHDATE	Month – Day – Year: 1918	
3.	RACE/ ETHNICITY	*(Check all that apply)* RACE a. American Indian/Alaskan Native b. Asian c. Black or African American d. Native Hawaiian or other Pacific Islander e. White ETHNICITY f. Hispanic or Latino	
4.	MARITAL STATUS	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced 6. Other	2
5.	LANGUAGE	Primary Language 0. English 1. Spanish 2. French 3. Other	0
6.	EDUCATION *(Highest Level Completed)*	1. No schooling 2. 8th grade/less 3. 9-11 grades 4. High school 5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree	2
7.	RESPONSIBILITY/ ADVANCE DIRECTIVES	*(Code for responsibility/advance directives)* 0. No 1. Yes a. Client has a legal guardian	0
		b. Client has advance medical directives in place (for example, a do not hospitalize order)	0

SECTION CC. REFERRAL ITEMS *(Complete at Intake Only)*

1.	DATE CASE OPENED/ REOPENED	Month – Day – Year: 1996	
2.	REASON FOR REFERRAL	1. Post hospital care 2. Community chronic care 3. Home placement screen 4. Eligibility for home care 5. Day care 6. Other	1
3.	GOALS OF CARE	*(Code for client/family understanding of goals of care)* 0. No 1. Yes	
		a. Skilled nursing treatments: 1 — d. Client/family education: 1	
		b. Monitoring to avoid clinical complications: 1 — e. Family respite: 1	
		c. Rehabilitation: 1 — f. Palliative care: -	
4.	TIME SINCE LAST HOSPITAL STAY	Time since discharge from last in-patient setting (*Code for most recent instance in LAST 180 DAYS*) 0. No hospitalization within 180 days 1. Within last week 2. Within 8 to 14 days 3. Within 15 to 30 days 4. More than 30 days ago	1
5.	WHERE LIVED AT TIME OF REFERRAL	1. Private home/apt. with no home care services 2. Private home/apt. with home care services 3. Board and care/assisted living/group home 4. Nursing home 5. Other	3
6.	WHO LIVED WITH AT REFERRAL	1. Lived alone 2. Lived with spouse only 3. Lived with spouse and other(s) 4. Lived with child (not spouse) 5. Lived with other(s) (not spouse or children) 6. Lived in group setting with non-relative(s)	2
7.	PRIOR NH PLACEMENT	Resided in a nursing home at anytime during **5 YEARS** prior to case opening 0. No 1. Yes	1
8.	RESIDENTIAL HISTORY	Moved to current residence within last two years 0. No 1. Yes	0

SECTION A. ASSESSMENT INFORMATION

1.	ASSESSMENT REFERENCE DATE	***Date of assessment*** Month – Day – Year: 2001

2.	REASONS FOR ASSESSMENT	***Type of assessment*** 1. Initial assessment 2. Follow-up assessment 3. Routine assessment at fixed intervals 4. Review within 30-day period prior to discharge from the program 5. Review at return from hospital 6. Change in status 7. Other	5

SECTION B. COGNITIVE PATTERNS

1.	MEMORY RECALL ABILITY	*(Code for recall of what was learned or known)* 0. Memory OK 1. Memory problem	
		a. Short-term memory OK — seems/appears to recall after 5 minutes	0
		b. Procedural memory OK—Can perform all or almost all steps in a multitask sequence without cues for initiation	0
2.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	a. How well client made decisions about organizing the day (e.g., when to get up or have meals, which clothes to wear or activities to do) 0. *INDEPENDENT*—Decisions consistent/reasonable/safe 1. *MODIFIED INDEPENDENCE*—Some difficulty in new situations only 2. *MINIMALLY IMPAIRED*—In specific situations, decisions become poor or unsafe and cues/supervision necessary at those times 3. *MODERATELY IMPAIRED*—Decisions consistently poor or unsafe, cues/supervision required at all times 4. *SEVERELY IMPAIRED*—Never/rarely made decisions	0
		b. Worsening of decision making as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) 0. No 1. Yes	0
3.	INDICATORS OF DELIRIUM	a. Sudden or new onset/change in mental function over **LAST 7 DAYS** (including ability to pay attention, awareness of surroundings, being coherent, unpredictable variation over course of day) 0. No 1. Yes	0
		b. In the **LAST 90 DAYS** (or since last assessment if less than 90 days), client has become agitated or disoriented such that his or her safety is endangered or client requires protection by others 0. No 1. Yes	0

SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	*(With hearing appliance if used)* 0. *HEARS ADEQUATELY*—Normal talk, TV, phone, doorbell 1. *MINIMAL DIFFICULTY*—When not in quiet setting 2. *HEARS IN SPECIAL SITUATIONS ONLY*—Speaker has to adjust tonal quality and speak distinctly 3. *HIGHLY IMPAIRED*—Absence of useful hearing	1
2.	MAKING SELF UNDERSTOOD (Expression)	*(Expressing information content—however able)* 0. *UNDERSTOOD*—Expresses ideas without difficulty 1. *USUALLY UNDERSTOOD*—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required 2. *OFTEN UNDERSTOOD*—Difficulty finding words or finishing thoughts, prompting usually required 3. *SOMETIMES UNDERSTOOD*—Ability is limited to making concrete requests 4. *RARELY/NEVER UNDERSTOOD*	0
3.	ABILITY TO UNDERSTAND OTHERS (Comprehension)	*(Understands verbal information—however able)* 0. *UNDERSTANDS*—Clear comprehension 1. *USUALLY UNDERSTANDS*—Misses some part/intent of message, BUT comprehends most conversation with little or no prompting 2. *OFTEN UNDERSTANDS*—Misses some part/intent of message; with prompting can often comprehend conversation 3. *SOMETIMES UNDERSTANDS*—Responds adequately to simple, direct communication 4. *RARELY/NEVER UNDERSTANDS*	1
4.	COMMUNICATION DECLINE	Worsening in communication (making self understood or understanding others) as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) 0. No 1. Yes	0

SECTION D. VISION PATTERNS

1.	VISION	*(Ability to see in adequate light and with glasses if used)* 0. *ADEQUATE*—Sees fine detail, including regular print in newspapers/books 1. *IMPAIRED*—Sees large print, but not regular print in newspapers/books 2. *MODERATELY IMPAIRED*—Limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—Object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—No vision or sees only light, colors, or shapes; eyes do not appear to follow objects	0
2.	VISUAL LIMITATION/ DIFFICULTIES	Saw halos or rings around lights, curtains over eyes, or flashes of lights 0. No 1. Yes	0
3.	VISION DECLINE	Worsening of vision as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) 0. No 1. Yes	0

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SECTION E. MOOD AND BEHAVIOR PATTERNS

1.	**INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD**	*(Code for observed indicators irrespective of the assumed cause)* 0. Indicator not exhibited in last 3 days 1. Exhibited 1-2 of last 3 days 2. Exhibited on each of last 3 days	
		a. A FEELING OF SADNESS OR BEING DEPRESSED, that life is not worth living, that nothing matters, that he or she is of no use to anyone or would rather be dead	0
		b. PERSISTENT ANGER WITH SELF OR OTHERS—e.g., easily annoyed, anger at care received	0
		c. EXPRESSIONS OF WHAT APPEAR TO BE UNREALISTIC FEARS—e.g., fear of being abandoned, left alone, being with others	0
		d. REPETITIVE HEALTH COMPLAINTS—e.g., persistently seeks medical attention, obsessive concern with body functions	0
		e. REPETITIVE ANXIOUS COMPLAINTS, CONCERNS—e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues	0
		f. SAD, PAINED, WORRIED FACIAL EXPRESSIONS—e.g., furrowed brows	0
		g. RECURRENT CRYING, TEARFULNESS	0
		h. WITHDRAWAL FROM ACTIVITIES OF INTEREST—e.g., no interest in long standing activities or being with family/friends	0
		i. REDUCED SOCIAL INTERACTION	1
2.	**MOOD DECLINE**	Mood indicators have become worse as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No 1. Yes	1
3.	**BEHAVIORAL SYMPTOMS**	Instances when client exhibited behavioral symptoms. If EXHIBITED, ease of altering the symptom when it occurred. 0. Did not occur in last 3 days 1. Occurred, easily altered 2. Occurred, not easily altered	
		a. WANDERING—Moved with no rational purpose, seemingly oblivious to needs or safety	0
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS—Threatened, screamed at, cursed at others	0
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS—Hit, shoved, scratched, sexually abused others	0
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS—Disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smears/throws food/feces, rummaging, repetitive behavior, rises early and causes disruption	0
		e. RESISTS CARE—Resisted taking medications/injections, ADL assistance, eating, or changes in position	0
4.	**CHANGES IN BEHAVIOR SYMPTOMS**	Behavioral symptoms have become worse or are less well tolerated by family as compared to **90 DAYS AGO** (or since last assessment if less than 90 days) 0. No, or no change in behavioral symptoms 1. Yes	1

SECTION F. SOCIAL FUNCTIONING

1.	**INVOLVEMENT**	a. At ease interacting with others (e.g., likes to spend time with others) 0. At ease 1. Not at ease	0
		b. Openly expresses conflict or anger with family/friends 0. No 1. Yes	0
2.	**CHANGE IN SOCIAL ACTIVITIES**	As compared to **90 DAYS AGO** (or since last assessment if less than 90 days ago), decline in the client's level of participation in social, religious, occupational or other preferred activities. IF THERE WAS A DECLINE, client distressed by this fact 0. No decline 1. Decline, not distressed 2. Decline, distressed	2
3.	**ISOLATION**	a. Length of time client is alone during the day (morning and afternoon) 0. Never or hardly ever 1. About one hour 2. Long periods of time—e.g., all morning 3. All of the time	2
		b. Client says or indicates that he/she feels lonely 0. No 1. Yes	1

SECTION G. INFORMAL SUPPORT SERVICES

			(A) Prim	(B) Secn
1.	**TWO KEY INFORMAL HELPERS** Primary (A) and Secondary (B)	NAME OF PRIMARY AND SECONDARY HELPERS		
		a. (Last/Family Name) Husband b. (First)		
		c. (Last/Family Name) Daughter d. (First)		
		e. Lives with client 0. Yes 1. No 2. No such helper [skip other items in the appropriate column]	1	1
		f. Relationship to client 0. Child or child-in-law 2. Other Relative 1. Spouse 3. Friend/neighbor	1	0
		Areas of help: 0. Yes 1. No		
		g. — Advice or emotional support	0	0
		h. — IADL care	0	1
		i. — ADL care	0	0
1.	**TWO KEY INFORMAL HELPERS** Primary (A) and Secondary (B) (cont)	If needed, willingness (with ability) to increase help: 0. More than 2 hours 1. 1-2 hours per day 2. No		
		j. — Advice or emotional support	0	1
		k. — IADL care	0	2
		l. — ADL care	0	2

2.	**CAREGIVER STATUS**	*(Check all that apply)*	
		A caregiver is unable to continue in caring activities—e.g., decline in the health of the caregiver makes it difficult to continue	a.
		Primary caregiver is not satisfied with support received from family and friends (e.g., other children of client)	b.
		Primary caregiver expresses feelings of distress, anger or depression	c.
		NONE OF ABOVE	d. X
3.	**EXTENT OF INFORMAL HELP (HOURS OF CARE, ROUNDED)**	For instrumental and personal activities of daily living received over the **LAST 7 DAYS**, indicate extent of help from family, friends, and neighbors	**HOURS**
		a. Sum of time across five weekdays	0 0 7
		b. Sum of time across two weekend days	0 0 3

SECTION H. PHYSICAL FUNCTIONING:
• IADL PERFORMANCE IN 7 DAYS
• ADL PERFORMANCE IN 3 DAYS

1. IADL SELF PERFORMANCE—Code for functioning in routine activities around the home or in the community during the **LAST 7 DAYS**,

(A) IADL SELF PERFORMANCE CODE (*Code for client's performance during LAST 7 DAYS*)
0. *INDEPENDENT*—did on own
1. *SOME HELP*—help some of the time
2. *FULL HELP*—performed with help all of the time
3. *BY OTHERS*—performed by others
8. *ACTIVITY DID NOT OCCUR*

(B) IADL DIFFICULTY CODE *How difficult it is (or would it be) for client to do activity on own*
0. *NO DIFFICULTY*
1. *SOME DIFFICULTY*—e.g., needs some help, is very slow, or fatigues
2. *GREAT DIFFICULTY*—e.g., little or no involvement in the activity is possible

	(A) Performance	(B) Difficulty
a. MEAL PREPARATION—How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food and utensils)	3	2
b. ORDINARY HOUSEWORK—How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)	3	2
c. MANAGING FINANCE—How bills are paid, checkbook is balanced, household expenses are balanced	0	0
d. MANAGING MEDICATIONS—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)	1	1
e. PHONE USE—How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)	0	0
f. SHOPPING—How shopping is performed for food and household items (e.g., selecting items, managing money)	3	2
g. TRANSPORTATION—How client travels by vehicle (e.g., gets to places beyond walking distance)	1	2

2. ADL SELF-PERFORMANCE—The following address the client's physical functioning in routine personal activities of daily life, for example, dressing, eating, etc. during the **LAST 3 DAYS, considering all episodes of these activities.** For clients who performed an activity independently, be sure to determine and record whether others encouraged the activity or were present to supervise or oversee the activity [*Note—For bathing, code for most dependent single episode in LAST 7 DAYS*]

0. *INDEPENDENT*—No help, setup, or oversight —OR— Help, setup, oversight provided only 1 or 2 times (with any task or subtask)
1. *SETUP HELP ONLY*—Article or device provided within reach of client 3 or more times
2. *SUPERVISION*—Oversight, encouragement or cueing provided 3 or more times during last 3 days —OR— Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision)
3. *LIMITED ASSISTANCE*—Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times —OR— Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help)
4. *EXTENSIVE ASSISTANCE*—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times:
   — Weight-bearing support —OR—
   — Full performance by another during part (but not all) of last 3 days
5. *MAXIMAL ASSISTANCE*—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times
6. *TOTAL DEPENDENCE*—Full performance of activity by another
8. *ACTIVITY DID NOT OCCUR* (regardless of ability)

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2.	ADL SELF-PERFORMANCE (cont)	
	a. MOBILITY IN BED—Including moving to and from lying position, turning side to side, and positioning body while in bed.	0
	b. TRANSFER—Including moving to and between surfaces—to/from bed, chair, wheelchair, standing position. [Note—Excludes to/from bath/toilet]	3
	c. LOCOMOTION IN HOME—[Note—If in wheelchair, self-sufficiency once in chair]	0
	d. LOCOMOTION OUTSIDE OF HOME—[Note—If in wheelchair, self-sufficiency once in chair]	0
	e. DRESSING UPPER BODY—How client dresses and undresses (street clothes, underwear) above the waist, includes prostheses, orthotics, fasteners, pullovers, etc.	3
	f. DRESSING LOWER BODY—How client dresses and undresses (street clothes, underwear) from the waist down, includes prostheses, orthotics, belts, pants, skirts, shoes, and fasteners	3
	g. EATING—Including taking in food by any method, including tube feedings.	0
	h. TOILET USE—Including using the toilet room or commode, bedpan, urinal, transferring on/off toilet, cleaning self after toilet use or incontinent episode, changing pad, managing any special devices required (ostomy or catheter), and adjusting clothes.	2
	i. PERSONAL HYGIENE—Including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (EXCLUDE baths and showers)	0
	j. BATHING—How client takes full-body bath/shower or sponge bath (EXCLUDE washing of back and hair). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. *Code for most dependent episode in LAST 7 DAYS*	2

3.	ADL DECLINE	ADL status has become worse (i.e., now more impaired in self performance) as compared to status 90 days ago (or since last assessment if less than 90 days) 0. No 1. Yes	1
4.	PRIMARY MODES OF LOCOMOTION	0. No assistive device 1. Cane 2. Walker/crutch 3. Scooter (e.g., Amigo) 4. Wheelchair 8. ACTIVITY DID NOT OCCUR	
		a. Indoors	3
		b. Outdoors	4
5.	STAIR CLIMBING	In the last 3 days, how client went up and down stairs (e.g., single or multiple steps, using handrail as needed) 0. Up and down stairs without help 1. Up and down stairs with help 2. Not go up and down stairs	2
6.	STAMINA	a. In a typical week, during the LAST 30 DAYS (or since last assessment), code the number of days client usually went out of the house or building in which client lives (no matter how short a time period) 0. Every day 1. 2-6 days a week 2. 1 day a week 3. No days	1
		b. Hours of physical activities in the last 3 days (e.g., walking, cleaning house, exercise) 0. Two or more hours 1. Less than two hours	1
7.	FUNCTIONAL POTENTIAL	Client believes he/she capable of increased functional independence (ADL, IADL, mobility)	a.
		Caregivers believe client is capable of increased functional independence (ADL, IADL, mobility)	b.
		Good prospects of recovery from current disease or conditions, improved health status expected	c.
		NONE OF ABOVE	d. X

SECTION I. CONTINENCE IN LAST 7 DAYS

1.	BLADDER CONTINENCE	a. In LAST 7 DAYS control of urinary bladder function (with appliances such as catheters or incontinence program employed) [Note—if dribbles, volume insufficient to soak through underpants] 0. *CONTINENT*—Complete control; DOES NOT USE any type of catheter or other urinary collection device 1. *CONTINENT WITH CATHETER*—Complete control with use of any type of catheter or urinary collection device that does not leak urine 2. *USUALLY CONTINENT*—Incontinent episodes once a week or less 3. *OCCASIONALLY INCONTINENT*—Incontinent episodes 2 or more times a week but not daily 4. *FREQUENTLY INCONTINENT*—Tends to be incontinent daily, but some control present 5. *INCONTINENT*—Inadequate control, multiple daily episodes 8. *DID NOT OCCUR*—No urine output from bladder	2
		b. Worsening of bladder incontinence as compared to status 90 DAYS AGO (or since last assessment if less than 90 days) 0. No 1. Yes	0
2.	BLADDER DEVICES	(*Check all that apply in LAST 7 DAYS*)	
		Use of pads or briefs to protect against wetness	a. X
		Use of an indwelling urinary catheter	b.
		NONE OF ABOVE	c.

3.	BOWEL CONTINENCE	In LAST 7 DAYS, control of bowel movement (with appliance or bowel continence program if employed) 0. *CONTINENT*—Complete control; DOES NOT USE ostomy device 1. *CONTINENT WITH OSTOMY*—Complete control with use of ostomy device that does not leak stool 2. *USUALLY CONTINENT*—Bowel incontinent episodes less than weekly 3. *OCCASIONALLY INCONTINENT*—Bowel incontinent episode once a week 4. *FREQUENTLY INCONTINENT*—Bowel incontinent episodes 2-3 times a week 5. *INCONTINENT*—Bowel incontinent all (or almost all) of the time 8. *DID NOT OCCUR*—No bowel movement during entire 7 day assessment period	0

SECTION J. DISEASE DIAGNOSES

Disease/infection that doctor has indicated is present and affects client's status, requires treatment, or symptom management. Also include if disease is monitored by a home care professional or is the reason for a hospitalization in LAST 90 DAYS (or since last assessment if less than 90 days)

[blank]. Not present
1. Present—not subject to focused treatment or monitoring by home care professional
2. Present—monitored or treated by home care professional
[If no disease in list, check J1ac, *None of Above*]

1. DISEASES			
HEART/CIRCULATION		p. Osteoporosis	
a. Cerebrovascular accident (stroke)		SENSES	
b. Congestive heart failure		q. Cataract	
c. Coronary artery disease		r. Glaucoma	
d. Hypertension	2	PSYCHIATRIC/MOOD	
e. Irregularly irregular pulse		s. Any psychiatric diagnosis	
f. Peripheral vascular disease		INFECTIONS	
NEUROLOGICAL		t. HIV infection	
g. Alzheimer's		u. Pneumonia	
h. Dementia other than Alzheimer's disease		v. Tuberculosis	
i. Head trauma		w. Urinary tract infection (in LAST 30 DAYS)	1
j. Hemiplegia/hemiparesis		OTHER DISEASES	
k. Multiple sclerosis		x. Cancer—(in past 5 years) not including skin cancer	
l. Parkinsonism		y. Diabetes	
MUSCULO-SKELETAL		z. Emphysema/COPD/asthma	
m. Arthritis		aa. Renal Failure	
n. Hip fracture	2	ab. Thyroid disease (hyper or hypo)	
o. Other fractures (e.g., wrist, vertebral)		ac. *NONE OF ABOVE*	ac.

2. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES		
a.		___ . __
b.		___ . __
c.		___ . __
d.		___ . __

SECTION K. HEALTH CONDITIONS AND PREVENTIVE HEALTH MEASURES

1.	PREVENTIVE HEALTH (PAST TWO YEARS)	(*Check all that apply—in PAST 2 YEARS*)	
		Blood pressure measured	a. X
		Received influenza vaccination	b. X
		Test for blood in stool or screening endoscopy	c.
		IF FEMALE: Received breast examination or mammography	d.
		NONE OF ABOVE	e.

2.	PROBLEM CONDITIONS PRESENT ON 2 OR MORE DAYS	(*Check all that were present on at least 2 of the last 3 days*)			
		Diarrhea	a.	Loss of appetite	d.
		Difficulty urinating or urinating 3 or more times at night	b.	Vomiting	e.
		Fever	c.	*NONE OF ABOVE*	f. X
3.	PROBLEM CONDITIONS	(*Check all present at any point during last 3 days*)			
		PHYSICAL HEALTH		Shortness of breath	e.
		Chest pain/pressure at rest or on exertion	a.	MENTAL HEALTH	
		No bowel movement in 3 days	b.	Delusions	f.
		Dizziness or lightheadedness	c.	Hallucinations	g.
		Edema	d. X	*NONE OF ABOVE*	h.

4.	PAIN	a. Frequency with which client complains or shows evidence of pain 0. No pain (score b-e as 0) 2. Daily - one period 1. Less than daily 3. Daily - multiple periods (e.g., morning and evening)	3
		b. Intensity of pain 0. No pain 2. Moderate 4. Times when pain is horrible or excruciating 1. Mild 3. Severe	2
		c. From client's point of view, pain intensity disrupts usual activities 0. No 1. Yes	1
		d. Character of pain 0. No pain 1. Localized - single site 2. Multiple sites	2
		e. From client's point of view, medications adequately control pain 0. Yes or no pain 1. Medications do not adequately control pain 2. Pain present, medication not taken	1
5.	FALLS FREQUENCY	Number of times fell in **LAST 90 DAYS** (or since last assessment if less than 90 days) If none, code "0"; if more than 9, code "9"	1
6.	DANGER OF FALL	(*Code for danger of falling*) 0. No 1. Yes	
		a. Unsteady gait	1
		b. Client limits going outdoors due to fear of falling (e.g., stopped using bus, goes out only with others)	0
7.	LIFE STYLE (Drinking/ Smoking)	(*Code for drinking or smoking*) 0. No 1. Yes	
		a. **In the LAST 90 DAYS** (or since last assessment if less than 90 days), client felt the need or was told by others to cut down on drinking, or others were concerned with client's drinking	0
		b. **In the LAST 90 DAYS** (or since last assessment if less than 90 days), client had to have a drink first thing in the morning to steady nerves (i.e., an "eye opener") or has been in trouble because of drinking	0
		c. Smoked or chewed tobacco daily	0
8.	HEALTH STATUS INDICATORS	(**Check all that apply**)	
		Client feels he/she has poor health (when asked)	a.
		Has conditions or diseases that make cognition, ADL, mood, or behavior patterns unstable (fluctuations, precarious, or deteriorating)	b.
		Experiencing a flare-up of a recurrent or chronic problem	c.
		Treatments changed in **LAST 30 DAYS** (or since last assessment if less than 30 days) because of a new acute episode or condition	d.
		Prognosis of less than six months to live—e.g., physician has told client or client's family that client has end-stage disease	e. 0
		NONE OF ABOVE	f. 0
9.	OTHER STATUS INDICATORS	(**Check all that apply**)	
		Fearful of a family member or caregiver	a.
		Unusually poor hygiene	b.
		Unexplained injuries, broken bones, or burns	c.
		Neglected, abused, or mistreated	d.
		Physically restrained (e.g., limbs restrained, used bed rails, constrained to chair when sitting)	e.
		NONE OF ABOVE	f. X

SECTION L. NUTRITION/HYDRATION STATUS

1.	WEIGHT	(*Code for weight items*) 0. No 1. Yes	
		a. Unintended weight loss of 5% or more in the **LAST 30 DAYS** [or 10% or more in the **LAST 180 DAYS**]	1
		b. Severe malnutrion (cachexia)	0
		c. Morbid obesity	0
2.	CONSUMP-TION	(*Code for consumption*) 0. No 1. Yes	
		a. **In at least 2 of the last 3 days,** ate one or fewer meals a day	0
		b. **In last 3 days,** noticeable decrease in the amount of food client usually eats or fluids usually consumes	
		c. Insufficient fluid—did not consume all/almost all fluids during last 3 days	0
		d. Enteral tube feeding	0
3.	SWALLOWING	0. *NORMAL*—Safe and efficient swallowing of all diet consistencies 1. *REQUIRES DIET MODIFICATION TO SWALLOW SOLID FOODS* (mechanical diet or able to ingest specific foods only) 2. *REQUIRES MODIFICATION TO SWALLOW SOLID FOODS AND LIQUIDS* (puree, thickened liquids) 3. *COMBINED ORAL AND TUBE FEEDING* 4. *NO ORAL INTAKE* (*NPO*)	0

SECTION M. DENTAL STATUS (ORAL HEALTH)

1.	ORAL STATUS	(**Check all that apply**)	
		Problem chewing (e.g., poor mastication, immobile jaw, surgical resection, decreased sensation/motor control, pain while eating)	a.
		Mouth is "dry" when eating a meal	b.
		Problem brushing teeth or dentures	c.
		NONE OF ABOVE	d. X

SECTION N. SKIN CONDITION

1.	SKIN PROBLEMS	Any troubling skin conditions or changes in skin condition (e.g., burns, bruises, rashes, itchiness, body lice, scabies) 0. No 1. Yes	1
2.	ULCERS (Pressure/ Stasis)	Presence of an ulcer anywhere on the body. Ulcers include any area of persistent skin redness (Stage 1); partial loss of skin layers (Stage 2); deep craters in the skin (Stage 3); breaks in skin exposing muscle or bone (Stage 4). [**Code 0 if no ulcer, otherwise record the highest ulcer stage (Stage 1-4).**]	
		a. **Pressure ulcer**—any lesion caused by pressure, shear forces, resulting in damage of underlying tissues	0
		b. **Stasis ulcer**—open lesion caused by poor circulation in the lower extremities	0
3.	OTHER SKIN PROBLEMS REQUIRING TREATMENT	(*Check all that apply*)	
		Burns (second or third degree)	a.
		Open lesions other than ulcers, rashes, cuts (e.g., cancer)	b.
		Skin tears or cuts	c.
		Surgical wound	d.
		Corns, calluses, structural problems, infections, fungi	e.
		NONE OF ABOVE	f. X
4.	HISTORY OF RESOLVED PRESSURE ULCERS	Client previously had (at any time) or has an ulcer anywhere on the body 0. No 1. Yes	0
5.	WOUND/ ULCER CARE	(*Check for formal care in LAST 7 DAYS*)	
		Antibiotics, systemic or topical	a. X
		Dressings	b. X
		Surgical wound care	c.
		Other wound/ulcer care (e.g., pressure relieving device, nutrition, turning, debridement)	d.
		NONE OF ABOVE	e.

SECTION O. ENVIRONMENTAL ASSESSMENT

1.	HOME ENVIRON-MENT [Check any of following that make home environment hazardous or uninhabitable (if none apply, check *NONE OF ABOVE*; if temporarily in institution, base assessment on home visit)]	Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors)	a.
		Flooring and carpeting (e.g., holes in floor, electric wires where client walks, scatter rugs)	b. X
		Bathroom and toiletroom (e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)	c.
		Kitchen (e.g., dangerous stove, inoperative refrigerator, infestation by rats or bugs)	d.
		Heating and cooling (e.g., too hot in summer, too cold in winter, wood stove in a home with an asthmatic)	e.
		Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street)	f.
		Access to home (e.g., difficulty entering/leaving home)	g.
		Access to rooms in house (e.g., unable to climb stairs)	h.
		NONE OF ABOVE	i.
2.	LIVING ARRANGE-MENT	a. As compared to **90 DAYS AGO** (or since last assessment), client now lives with other persons—e.g., moved in with another person, other moved in with client 0. No 1. Yes	0
		b. Client or primary caregiver feels that client would be better off in another living environment 0. No 1. Client only 2. Caregiver only 3. Client and caregiver	1

SECTION P. SERVICE UTILIZATION (IN LAST 7 DAYS)

1. FORMAL CARE (Minutes rounded to even 10 minutes) — Extent of care or care management in **LAST 7 DAYS** (or since last assessment if less than 7 days) involving

	(A) # of Days	(B) Hours	(C) Mins
a. Home health aides	7	7	00
b. Visiting nurses	2	0	30
c. Homemaking services			
d. Meals	7	3	15
e. Volunteer services			
f. Physical therapy			
g. Occupational therapy			
h. Speech therapy			
i. Day care or day hospital			
j. Social worker in home			

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2.	SPECIAL TREATMENTS, THERAPIES, PROGRAMS	Special treatments, therapies, and programs received or scheduled during the **LAST 7 DAYS** (or since last assessment if less than 7 days) and adherence to the required schedule. Includes services received in the home or on an outpatient basis. [Blank]. Not applicable 1. Scheduled, full adherence as prescribed 2. Scheduled, partial adherence 3. Scheduled, not received [If no treatments provided, check *NONE OF ABOVE* **P2aa**]			
		RESPIRATORY TREATMENTS		o. Occupational therapy	
		a. Oxygen		p. Physical therapy	
		b. Respirator for assistive breathing		**PROGRAMS**	
		c. All other respiratory treatments		q. Day center	
		OTHER TREATMENTS		r. Day hospital	
		d. Alcohol/drug treatment program		s. Hospice care	
		e. Blood transfusion(s)		t. Physician or clinic visit	1
		f. Chemotherapy		u. Respite care	
		g. Dialysis		**SPECIAL PROCEDURES DONE IN HOME**	
		h. IV infusion - central		v. Daily nurse monitoring (e.g., EKG, urinary output)	
		i. IV infusion - peripheral		w. Nurse monitoring less than daily	1
		j. Medication by injection		x. Medical alert bracelet or electronic security alert	1
		k. Ostomy care		y. Skin treatment	
		l. Radiation		z. Special diet	
		m. Tracheostomy care		aa. *NONE OF ABOVE*	aa.
		THERAPIES			
		n. Exercise therapy			
3.	MANAGEMENT OF EQUIPMENT (In Last 3 Days)	**Management codes:** 0. Not used 1. Managed on own 2. Managed on own if laid out or with verbal reminders 3. Partially performed by others 4. Fully performed by others			
		a. Oxygen	0	c. Catheter	0
		b. IV	0	d. Ostomy	0
4.	VISITS IN LAST 90 DAYS OR SINCE LAST ASSESSMENT	***Enter 0 if none, if more than 9, code "9"***			
		a. Number of times ADMITTED TO HOSPITAL **with** an overnight stay			1
		b. Number of times VISITED EMERGENCY ROOM **without** an overnight stay			0
		c. EMERGENT CARE—including unscheduled nursing, physician, or therapeutic visits to office or home			0
5.	TREATMENT GOALS	Any treatment goals that have been met in the **LAST 90 DAYS** (or since last assessment if less than 90 days) 0. No 1. Yes			1
6.	OVERALL CHANGE IN CARE NEEDS	Overall self sufficiency has changed significantly as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports 2. Deteriorated—receives more support			2
7.	TRADE OFFS	Because of limited funds, during the last month, client made trade-offs among purchasing any of the following: prescribed medications, sufficient home heat, necessary physician care, adequate food, home care 0. No 1. Yes			0

SECTION Q. MEDICATIONS

1.	NUMBER OF MEDICATIONS	Record the number of different medicines (prescriptions and over the counter), including eye drops, taken regularly or on an occasional basis in the **LAST 7 DAYS** (or since last assessment)[*If none, code "0", if more than 9, code "9"*]			
2.	RECEIPT OF PSYCHOTROPIC MEDICATION	Psychotropic medications taken in the **LAST 7 DAYS** (or since last assessment) [Note—Review client's medications with the list that applies to the following categories] 0. No 1. Yes			
		a. Antipsychotic/neuroleptic	1	c. Antidepressant	0
		b. Anxiolytic	0	d. Hypnotic	0
3.	MEDICAL OVERSIGHT	Physician reviewed client's medications as a whole in **LAST 180 DAYS** (or since last assessment) 0. Discussed with at least one physician (or no medication taken) 1. No single physician reviewed all medications			0
4.	COMPLIANCE/ ADHERENCE WITH MEDICATIONS	Compliant all or most of time with **medications** prescribed by physician (both during and between therapy visits) in **LAST 7 DAYS** 0. Always compliant 1. Compliant 80% of time or more 2. Compliant less than 80% of time, including failure to purchase prescribed medications 3. *NO MEDICATIONS PRESCRIBED*			0

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

5.	LIST OF ALL MEDICATIONS	List prescribed and nonprescribed medications taken in **LAST 7 DAYS** (or since last assessment) **a. Name and Dose**—Record the name of the medication and dose ordered. **b. Form:** Code the route of Administration using the following list: 1. By mouth (PO) 2. Sub lingual (SL) 3. Intramuscular (IM) 4. Intravenous (IV) 5. Subcutaneous (SQ) 6. Rectal (R) 7. Topical 8. Inhalation 9. Enteral tube 10. Other **c. Number taken**—Record the amount of medication administered each time the medication is given **d. Freq:** Code the number of times per day, week, or month the medication is administered using the following list: PRN. As necessary QH. Every hour Q2H. Every two hours Q3H. Every three hours Q4H. Every four hours Q6H. Every six hours Q8H. Every eight hours QD. Once daily BID. Two times daily (includes every 12 hrs) TID. Three times daily QID. Four times daily 5D. Five times daily QOD. Every other day QW. Once each wk 2W. Two times every week 3W. Three times every week 4W. Four times each week 5W. Five times each week 6W. Six times each week 1M. Once every month 2M. Twice every month C. Continuous O. Other

a. Name and Dose	b. Form	c. Number Taken	d. Freq.
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			
k.			

SECTION R. ASSESSMENT INFORMATION

1.	**SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:**		
a. Signature of Assessment Coordinator			
b. Title of Assessment Coordinator			
c. Date Assessment Coordinator signed as complete	1 1 – 0 5 – 2 0 0 1 (Month – Day – Year)		
d. Other Signatures	Title	Sections	Date
e.			Date
f.			Date
g.			Date
h.			Date
i.			Date

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[a] Country specific

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Appendix 2: Example of an EASY-Care assessment sheet

Revised EASY-CARE

ID number: ______________________ **Age:**

D.o.B.: ______________________ **Gender:** Male/Female

Religion: ______________________ **Ethnicity:**

Hospital in-patient admissions in past 12 months:	
Permanent or long-standing health conditions or disabilities:	

Date of Assessment: ______________________

How Are You Doing?

1. **In general, would you say your health is** ★

Excellent	☐	*Comments:*
Very good	☐	
Good	☐	
Fair	☐	
Poor	☐	

2. **In general, do you feel you are able to enjoy life to the full**
(eg, able to pursue leisure interests, hobbies, learning, work, etc.)

Yes	☐	*Comments:*
No	☐	

3. **Can you see?** (with glasses if worn) ★

Yes	☐	*Comments:*
With difficulty	☐	
Cannot see at all	☐	

v

4. **Can you hear?** (with hearing aid if worn) ★

Yes .... ☐

With difficulty .... ☐

Cannot hear at all .... ☐

Comments:

5. **Do you have difficulty in making yourself understood because of problems with your speech?** ★

No difficulty .... ☐

Difficulty with some people .... ☐

Considerable difficulty with everybody .... ☐

Comments:

6. **Do you have difficulty chewing food?** (with dentures if worn) ★

No difficulty .... ☐

Some difficulty .... ☐

Unable to chew .... ☐

Comments:

7. **Have you lost weight in the last six months?** **Yes** **No**

If Yes, how much? (in kg or lbs) ☐

Further assessment required if weight loss > 6kg/1 stone

Comments: ____________________

8. **Do you have problems with your feet?** (e.g., cutting toe nails, painful corns)

No problems .... ☐

Some problems .... ☐

Comments:

9. **How many falls have you had over the last six months?**

None .... ☐

One .... ☐

Two or more .... ☐

Comments:

10. How much bodily pain have you had over the past 4 weeks?

None .... ☐
Very mild .... ☐
Mild .... ☐
Moderate .... ☐
Severe .... ☐

Comments:

11. Are you basically satisfied with your life? ★ .... ☐ Yes ☐ NO

12. Do you feel your life is empty? ★ .... ☐ YES ☐ No

13. Are you afraid something bad is going to happen to you? ★ ... ☐ YES ☐ No

14. Do you feel happy most of the time? ★ .... ☐ Yes ☐ NO

Notes on Questions 11-14:
1. Score 1 for each symptom of depression (UPPER CASE).
2. A score of 1 or more indicates the possible presence of depression.

15. Do you feel lonely? ★

Never .... ☐
Sometimes .... ☐
Often .... ☐

Comments:

16. Have you had trouble sleeping over the past month?

No .... ☐
Yes .... ☐

Comments:

17. Do you get short of breath on minimal exertion? .... ☐ No ☐ Yes

Comments: ______________________

18. List current medical problems (assessor to complete with the older person)

D. Abilities

Domestic

19. Can you use the telephone? ★

Without help, including looking up numbers and dialling .... ☐ 3

With some help .... ☐ 1

Or are you completely unable to use the telephone? .... ☐ 0

Comments: ______________________________

Managing Money & Medicines

20. Can you handle your own money (e.g., pay bills, count money, etc.) ★

Without help .... ☐ 3

With some help .... ☐ 1

Or are you completely unable to handle your own money? .... ☐ 0

Comments: ______________________________

21. Can you take your own medicine? ★

Without help (in the right doses and at the right time) .... ☐ 4

With some help (able to take medicine if someone prepares it for you and/or reminds you to take it) .... ☐ 2

Or are you completely unable to take your medicine? .... ☐ 0

Comments: ______________________________

Getting Around

22. Can you walk outside? ★

Without help .... ☐ 6

With some help .... ☐ 4

Or are you completely unable to .... ☐ 0

Comments: ______________________________

23. **Can you get around indoors? ★**

Without help .... ☐ 9

In a wheelchair without help .... ☐ 6

With some help .... ☐ 4

Or are you confined to bed? .... ☐ 0

Comments: ____

24. **Can you manage stairs? ★**

Without help (including carrying any walking aid) .... ☐ 5

With some help .... ☐ 2

Or are you unable to manage stairs? .... ☐ 0

Comments: ____

25. **Can you move yourself from bed to chair, if next to each other? ★**

Without help .... ☐ 7

With some help .... ☐ 5

Or are you completely unable to move from bed to chair? .... ☐ 0

Comments: ____

Personal Care

26. **Can you use the toilet (or commode)? ★**

Without help (can reach toilet/commode, undress sufficiently, clean self and leave) .... ☐ 8

With some help (can do some things, including wiping self) .... ☐ 5

Or are you completely unable to use the toilet/commode? .... ☐ 0

Comments: ____

27. **Can you use the bath or shower? ★**

Without help .... ☐ 6

Or do you need help with using the bath or shower .... ☐ 0

Comments: ____

28. Can you keep up your personal appearance? ★
(e.g., brush hair, shave, put on make-up, etc.)

Without help .... ☐ 5

Or do you need help with keeping up your personal appearance? ..... ☐ 0

Comments: ______

29. Can you dress yourself? ★

Without help (including buttons, zips, laces, etc) .... ☐ 6

With some help (can do half unaided) .... ☐ 3

Or are you completely unable to dress yourself? .... ☐ 0

Comments: ______

30. Can you feed yourself? ★

Without help .... ☐ 8

With some help (cutting food up, spreading butter, etc) .... ☐ 5

Or are you completely unable to feed yourself? .... ☐ 0

Comments: ______

Continence

31. Do you have accidents with your bladder? (incontinence of urine) ★

No accidents .... ☐ 8

Yes, occasional accident (less than once a day) .... ☐ 6

Or do you have frequent accidents (once a day or more)
or need help with urinary catheter? .... ☐ 0

Comments: ______

32. Do you have accidents with your bowels? (incontinence of faeces) ★

No accidents .... ☐ 9

Yes, occasional accident (less than once a week) .... ☐ 6

Or do you have frequent accidents or need to be given an enema? .... ☐ 0

Comments: ______

ABILITY SCORE (questions 19 to 35) ______ **(maximum 100)**

x

E. Memory

(This section should be used only if the assessor is trained in its use, and in how to respond to any problems which are identified.)

Item		Max Error	Score		Weight		
33.	**What year is it now?** ★	1	______	x	4	=	______
34.	**What month is it now?** ★	1	______	x	3	=	______

Memory Phrase ★

Repeat this phrase after me:

Mr John Brown, 42 West Street Sheffield

Item		Max Error	Score		Weight		
35.	**What time is it? (within one hour)** ★	1	______	x	3	=	______
36.	**Count backwards 20 to 1** ★	2	______	x	2	=	______
37.	**Say the months in reverse order** ★	2	______	x	2	=	______
38.	**Repeat the memory phrase** ★	5	______	x	2	=	______
					Total	=	______

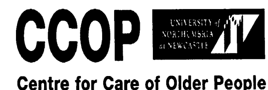
Notes on Questions 36-41:

1. Score of 1 for each incorrect response; maximum weighted error source = 28

Score:	0 – 10	indicates normal or mild impairment
	11 – 28	*indicates moderate to severe impairment

Other information

Appendix 3: Letter to home manager



Room H010
NRDU
Coach Lane East
Coach Lane
Newcastle upon Tyne
NE7 7XA
Tel. No. (0191) 215 6048
Fax. (0191) 215 6083

Dear Colleague

My colleagues and I in conjunction with the Joseph Rowntree Foundation are conducting an audit project, which involves comparing the MDS assessment with the Registered Nursing Care Contribution (RNCC) assessment. Chrysa Apps has identified your Care Home as a possible venue for the study to take place. I have enclosed some information regarding the study for you to view and would ask you to contact me at the above address if you are willing to place part. If you would like to ask any questions about the study before deciding to take part please do not hesitate to contact me on the above telephone number or email margaret2.cook@unn.ac.uk May I take the opportunity to thank you for your support.

Yours sincerely

Margaret Cook
Senior Research Assistant

Appendix 4: RNCC documentation and guidance

The Registered Nursing Care Contribution: definitions for use
Highly complex: Physical and mental needs are highly complex; mechanical/technical and/or therapeutic intervention are needed *frequently*, including *frequent* reassessment over a 24-hour period.

Medium complexity: Physical and mental needs are moderately complex; mechanical/technical and/or therapeutic assistance are needed *regularly* or *intermittently*. The interventions require regular reassessment.

At risk: Abilities are compromised or absent most or all of the time; sensory loss is multiple; self-image is low. Frequent reassessment of risk is needed.

Minimal risk: Abilities present most of the time, but there is a need for regular reassessment of risk.

Unpredictable: How the patient responds to their health or disease processes/disorder or to any internal or external triggers cannot be anticipated with certainty, and there is a requirement for ongoing assessment, care planning, intervention and review.

Predictable: How the patient responds to their health or disease processes/disorder or to any internal or external triggers can be anticipated with some certainty through established interventions and regularly reviewed care plans.

Unstable: A fluctuating disease process/disorder, and/or emotional, physical, behavioural and psychosocial conditions, resulting in an alternating health state and requiring frequent or regular intervention or treatment.

Stable: Health or disease process/disorder, including emotional, physical, behavioural and psychosocial needs, is in a steady state, and is likely to remain so if correct treatment/care regimes continue.

- Remember that care from a registered nurse includes time spent in direct contact with the patient, but also that spent in planning, supervising and monitoring care delivered by someone else – who may or may not be a registered nurse.
- It is essential to consider each person holistically in order to determine the full range of needs identified from the assessment. Think carefully about each category of physical and mental need and reflect on whether a need in one field is likely to impact on another, thereby increasing the patient's overall dependency and their requirement for care by a registered nurse.
- Consider the stability, predictability, risk and complexity of needs, and the patient's requirements for care and reassessment by a registered nurse against each of these dimensions. Take full account of the changes that can occur over a period of a week or a number of weeks, rather than attempting to make a judgement as a snapshot of a particular time. If the person is currently stable, but is often unpredictable, this should be reflected in the determination.
- Using the information presented by the assessment and care plans, and using your professional skill and judgement, write a description of the registered nursing input required. Include all the relevant details to enable you to draw a conclusion concerning the appropriate level of registered nursing support that offers the 'best fit' for this person, and to demonstrate the reasons for your decision.

- The decision you make should be based on the patient's current and anticipated health status. Review and reassessment will be undertaken three months following placement and at least annually thereafter, or when there is a significant change in the patient's health status.
- You must support your decision about the band of need for registered nursing care with a rationale based on the evidence and information available to you and drawing on your professional knowledge, skills and experience. You should express this rationale as clearly as you can, and avoid using jargon if possible, making clear the key aspects of need that informed your decision.

Determining care from a registered nurse
The form reproduced below should be used to record the determination of registered nursing care for the person in one of three bandings: high, medium or low, within the framework of *stability, predictability, risk and complexity*. In making this determination, a holistic approach should be followed and consideration given to the totality of information gained from the domains of the single assessment and the care plan, which will also have addressed the key dimensions of instability, predictability, intensity, risk and complexity of needs. This information should be used by the designated NHS nurses alongside their professional skills, knowledge and observations of the individual concerned, to inform the determination of registered nursing care needs within a nursing home setting. In evaluating all assessment information, full account must be taken of the prognosis of people's conditions and the likely outcomes if help were not to be provided, or was provided in different ways. Attention should be paid to the full range of a person's problems, and not just those for which a nursing response is immediately obvious.

Professional judgement and an understanding of what is meant by terms such as stability, predictability and risk are essential in applying the RNCC tool. There will be different permutations in different situations. There can sometimes be unpredictability within a generally stable state. In making the determination of banding, designated nurses need to think about which offers the 'best fit' in matching the needs of the patient. The judgement about stability or unpredictability should not be made as a snapshot at a moment in time, but should take full account of what is known about the person's condition and their usual behaviour over the course of a week or a number of weeks.

The high band
People with high needs for registered nursing care will have complex needs that require frequent mechanical, technical and/or therapeutic interventions. They will need frequent intervention and reassessment by a registered nurse throughout a 24-hour period, and their physical/mental health state will be unstable and/or unpredictable.

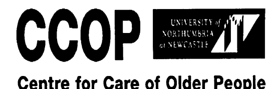
The medium band
People whose needs for registered nursing care are judged to be in the medium banding may have multiple care needs. They will require the intervention of a registered nurse on at least a daily basis, and may need access to a nurse at any time. However, their condition (including physical, behavioural and psychosocial needs) is stable and predictable, and likely to remain so if treatment and care regimes continue.

The low band
The low band of need for nursing care will apply to people *who are self-funding* whose care needs can be met with minimal registered nurse input. Assessment will indicate that their needs could normally be met in another setting (such as at home, or in a care home that does not provide nursing care, with support from the district nurse), but they have chosen to place themselves in a nursing home. (Department of Health, 2001b, p. 14)

Resident's ID number:

Band	Decision (Tick relevant box)	Rationale
High Unstable and or unpredictable, at risk Complex needs (Needs frequent registered nursing intervention over 24 hours)		
Medium Stable and / or predictable, minimal risk (Needs daily intervention by a registered nurse and may need access to a nurse at any time)		
Low Self-selected placement, care could be provided in another setting with minimal registered nurse intervention		

Appendix 5: Letter to care home staff and information sheet



Room H010
Centre for Care of Older People
Faculty of Health, Social Work & Education
University of Northumbria at Newcastle
Coach Lane Campus East
Coach Lane
Newcastle upon Tyne
NE7 7XA
Tel. No. (0191) 215 6048
Fax. (0191) 215 6083

Dear

As outlined during our telephone conversation, my colleagues and I, in conjunction with the Joseph Rowntree Foundation are conducting an audit project, which involves comparing the MDS assessment with the Registered Nursing Care Contribution (RNCC) and the Easy-Care assessment tools. I have enclosed some information regarding the study for you to view and show to your colleagues and residents.

Please contact me at the above address to arrange dates for your Care Home to participate. If you, your staff and/or residents would like to ask any questions about the study before deciding on a date to take part please do not hesitate to contact me on the above telephone number or email margaret2.cook@unn.ac.uk

May I take the opportunity to thank you for your support.

Yours sincerely

Margaret Cook
Senior Research Assistant

CCOP University of Northumbria at Newcastle
Centre for Care of Older People

Staff Information Sheet:

An audit project comparing the RNCC tool with the MDS and Easy-Care tools.

The Government's recent initiatives around nursing and residential home care for older people are an attempt to develop an assessment process, which ensures that older people get the care that they need. This aim includes ensuring that people get enough care or at least care which is state-funded up to a level where it is necessary. Care that is beyond this level is expensive and ineffective, especially as it may contribute towards undermining independence.

Two recent initiatives are attempts to address these issues:

1. The first is the development of the **Single Assessment process**, where agencies are required to develop a co-ordinated system for assessment.
2. The second is the development of the **Registered Nursing Care Contribution** (RNCC) tool, to be used to assess the amount of nursing care that an older person needs, and which will be funded by the NHS rather than by the older person.

The RNCC tool assesses the older person as being in one of three "bands" of nursing care, low, medium or high. These bands are based on the type of care that the person needs – i.e. whether it needs a trained nurse to deliver some or all care, and also on the requirement for monitoring and overview – i.e. the extent to which the person's condition is stable and predictable. People, who need substantial trained nursing input and whose condition is unstable and requires constant monitoring and rapid response, are placed in the high band of nursing care.

The MDS tool is designed to distinguish between residents of different levels of need across seven categories. The correspondence between category and staff input has been established producing two categories, enhanced and standard nursing care for the purpose of costing required staff time.

The questions for this study are:

1. Do the two tools produce similar assessments when used on the same people?
2. Does the RNCC tool have the same degree of user-acceptability and inter-rater reliability as the MDS tool?

Homes using MDS were invited to take part in the study in which registered nursing staff are asked to assess nursing care residents using the RNCC tool.

The researcher will collect MDS data plus extract data from the notes and records of each resident appropriate with that used by the RNCC. Any information collected will be treated in the strictest confidence. The resident's identity will not be divulged to any third party. All records stored by us will be anonymised.

The RNCC data sets will then be translated into RNCC bands by:

a) The researcher and
b) Nurses working in the other homes in the study.

The researcher will also assess consenting residents using a reduced version of the Easy-Care tool. Easy-Care was developed to support integrated assessment of physical, mental and social care needs of older people. It is currently used in 18 countries worldwide. It provides prompts where further action is required and summary scores for independence in functional abilities, depression, and cognitive impairment and alcohol problems.

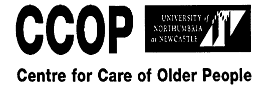
This will produce:

- One set of MDS scores for each resident.
- Three sets of RNCC scores for each resident:
    1. From staff in the residents care home,
    2. From the researcher,
    3. From staff in another care home
- One set of Easy-Care scores for consenting residents.

Analysis
Data will be analysed:

1. To determine the degree of correlation between the MDS scores and the RNCC tool.
2. To determine the inter-rater reliability of the RNCC tool.

Appendix 6: Residents' letter and information sheet



Room H010
NRDU
Coach Lane East
Coach Lane
Newcastle upon Tyne
NE7 7XA
Tel. No. (0191) 215 6048
Fax. (0191) 215 6083

Dear

Researchers at the University of Northumbria and the Joseph Rowntree Foundation are running an audit study comparing assessment tools used to assess Nursing Home residents' nursing care needs.

Your Nursing Home has been identified as a possible venue for the study to take place and I would like to invite you to take part. Taking part would involve me visiting you in your Nursing Home and asking you questions about your health. This is expected to take about one hour of your time. I have enclosed an information sheet about the study to help you decide if you wish to take part or not. If you need further information to help you decide, please do not hesitate to contact me at the number given above. I will also make myself available to you prior to commencing the study so you can direct any questions you may have directly to me.

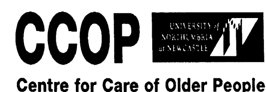
If willing to take part would you please complete the reply slip and give it to your Head of Nursing and she will forward it on to me. If you do not wish to take part, you do not have to do anything but it would help if you could indicate your decision on the reply slip.

Any information you do provide will be treated in the strictest confidence and in accordance with the principles of the Data Protection Act 1998.

May I take the opportunity to thank you for your time and support.

Yours sincerely

Margaret Cook
Senior Research Assistant



Mrs …………

Room ………..

Reply Slip.

Please tick the appropriate box.

I am willing to participate in the study. ☐

I wish more information before deciding. ☐

I do not wish to take part in the study. ☐

Please give the completed reply slip to your Head of Nursing

CCOP UNIVERSITY of NORTHUMBRIA at NEWCASTLE
Centre for Care of Older People

Residents' Information

As from October 2001 there have been changes in the way the funding of nursing care received by residents of Nursing Homes is organised. The NHS will now pay nursing care and its contribution will be calculated using a new tool developed for the purpose: the Registered Nursing Care Contribution tool (RNCC). In order for this tool to do its job effectively and accurately it needs to have a sound basis and be compatible with other assessment tools in current use. These changes will not affect the way your care is delivered.

This audit study will compare the results of using the RNCC tool and an established assessment tool: the MDS, currently used by the nursing staff in your Nursing Home.

In order to compare these tools we need your consent to ask you questions relating to your health and social care needs as well as having access to your nursing notes held by the Nursing Home. It will involve me visiting you in the Nursing Home and spending approximately one hour with you and your notes.

Any information you give to us will be treated in the strictest confidence. Your identity will not be divulged to any third party. All records stored by us will be anonymised.

If you or your family would like to ask any questions about the study before deciding to take part please do not hesitate to contact me on (0191) 215 6048. If I am unavailable please leave your name and telephone number and I will return your call. If this is unsuitable then please ask the home manager to contact me and I will make myself available to answer any queries you or your family may have.

Thank you for your help and support.

Margaret Cook
Senior Research Assistant

Appendix 7: Examples of Care Plans

Examples of CARE PLAN: PROBLEM No:

RESIDENT: **D.O.B.** **ROOM No:**

PRESENTING PROBLEM	**ANXIETY WHEN MOBILISING DUE TO PREVIOUS HISTORY OF FALLS**

AIM	**TO MAXIMISE RESIDENT ABILITY TO MOBILISE ENCOURAGING INDEPENDENCE WHERE POSSIBLE WHILST MAXIMISING THEIR SAFETY**

AGREED PLAN OF ACTION

Resident can mobilise using their Zimmer frame within the unit, but needs supervision. They tend to be rather impatient and hurry, making their gait unsteady and putting them at risk of further falls. (See risk assessment.)

Ensure resident has their call bell easily to hand at all times, so that they can summon help when required.

ENSURE RESIDENT MANUAL HANDLING ASSESSMENT IS REFERRED TO!

Resident requires one carer in attendance at all times when mobilising, to provide reassurance and encouragement.

Resident needs one carer to assist them out of an armchair or wheelchair and give them their Zimmer frame to mobilise – ensure gel cushion is *in situ*, which raises resident's seat and helps them to rise.

Resident can get out of bed alone if the bed is set at the lowest height and their Zimmer frame is at hand, but they require the help of one carer to fit appropriate footwear.

They also require the help of one carer to lift their legs into bed and remove footwear, when they retire for the night.

Resident needs the help of one carer to push them in a wheelchair when 'off unit', or when outside the building. They may require the use of a wheelchair within the unit if they are unwell or very tired.

Routine Review Due monthly
Sign: ……………………………………………………. Date: ……………………………..

CARE PLAN: PROBLEM No:

RESIDENT: **D.O.B.** **ROOM No:**

PRESENTING PROBLEM	RESIDENT REQUIRES HELP WITH THEIR PERSONAL HYGEINE AND DRESSING

AIM	TO ENSURE RESIDENT IS CLEAN AND WELL-GROOMED AT ALL TIMES

AGREED PLAN OF ACTION

Resident can wash their face and hands independently, but needs the help of one carer with all other washing needs – especially the lower half of their body as they cannot bend down.

Resident needs the help of one carer to dress or undress, with particular help needed with underwear and clothing on the lower half of their body.

Ensure resident can choose their own clothing or nightwear whenever possible.

Resident likes to bathe or shower at least weekly. Ensure they have a choice. They need the help of one carer to bathe (in Parker bath) or shower (using shower seat in their bathroom).

Ensure resident has the opportunity to regularly visit the Hairdresser at the unit and has the help of one carer to wash their hair if required.

Ensure resident has their toenails trimmed at regular intervals by the contracted chiropodist and that they are assisted in trimming their fingernails by care staff as required.

Routine Review Due monthly (see overleaf)

Sign: ………………………………………………….. **Date:** ……………………………

CARE PLAN: PROBLEM No:

RESIDENT: **D.O.B.** **ROOM No:**

PRESENTING PROBLEM	RESIDENT REQUIRES HELP TO USE THE TOILET (THEY ARE PRONE TO URINARY URGENCY)

AIM	TO ENSURE RESIDENT CAN USE THE TOILET WHEN THEY NEED TO DO SO, WHENEVER POSSIBLE

AGREED PLAN OF ACTION

Ensure the resident's call bell is easily at hand at all times.

Resident needs the help of one carer to access the toilet (see handling assessment). They need help to adjust their clothing when they get to the toilet and when they've finished, as they cannot bend down They are otherwise independent.

Unfortunately, they suffer from urinary urgency which, together with their poor mobility, often means they are incontinent – particularly at night.

Ensure they are reminded to go to the toilet regularly (at least 4-hourly) to give them the opportunity to pass urine or open their bowels, if they do not ask to go to the toilet. Try to establish a regular routine.

Use correctly assessed pads appropriately (see rear of bathroom door for correct types/sizes).

Resident prefers to use a commode at night which should be placed by the side of the bed with their Zimmer frame close by, but they need supervising and help to do so. Unfortunately, they are often incontinent and need frequent checking during the night.

Please encourage them to use their call bell at night so that they can be supervised.

Immediately report to the Nurse-in-Charge, any skin damage or other abnormalities (e.g. foul urine, blood loss etc.) or if resident seems to be having problems opening their bowels, and act on their instructions.

Routine Review Due monthly
Sign: …………………………………………………….. **Date: ……………………………..**

CARE PLAN: PROBLEM No:

RESIDENT: **D.O.B.** **ROOM No:**

PRESENTING PROBLEM	RISK OF PERSONAL INJURY (Risk assessment score 19) LONG HISTORY OF FALLS AND/OR MINOR INJURIES PRIOR TO ADMISSION

AIM	TO MINIMISE RISK OF INJURY TO RESIDENT

AGREED PLAN OF ACTION

Resident is already anxious about falls, but still mobilises on occasions without summoning aid. Please remind them to use their call bell to summon help before mobilising and ensure it is always close at hand.

Their skin is thin and vulnerable to injury, especially their lower legs which bear many scars from previous 'mishaps'. They have also had several severe falls resulting in bone injury, including a fractured pelvis, left hip and left humerus.

Supervise them when mobilising. Their sight and hearing is poor and they may be tired late in the day or during the night.

Please ensure their environment is as hazard-free as possible by removing obstructions from their path in good time whilst they are mobilising.

Also check that they have enough room for their legs under the dining table since their shins have been injured in the past by other resident's wheelchair footrests.

If any skin damage occurs or is observed, report this to the Nurse-in-Charge immediately and abide by their instructions.

Routine Review Due monthly (see overleaf)

Sign: .... **Date: ....**

CARE PLAN: PROBLEM No:

RESIDENT: **D.O.B.** **ROOM No:**

PRESENTING PROBLEM	PROFOUND DEAFNESS COMPLICATED BY POOR SIGHT (Caused by Macular Degeneration)

AIM	TO MAXIMISE COMMUNICATION WITH RESIDENT WITHIN THE LIMITS OF THEIR CONDITION

AGREED PLAN OF ACTION
Ensure resident wears their hearing aid at all times except when washing or when they are in bed. Ensure their hearing aid is operational – report any problems to the Nurse-in-Charge who can liaise with relatives. Use of a write-board to relay information is not possible due to the resident's poor eyesight. Resident is not always able to follow conversations, but has a limited ability to lip read. Speak clearly and directly to them. Repeat requests if required.

Routine Review Due monthly (see overleaf)

Sign: ……………………………………………………. **Date:** ……………………………..

CARE PLAN: PROBLEM No:

RESIDENT: **D.O.B.** **ROOM No:**

PRESENTING PROBLEM	**RESIDENT NEEDS ASSISTANCE TO SOCIALISE**

AIM	**TO GIVE RESIDENT AS MUCH OPPORTUNITY TO SOCIALISE WITHIN THE UNIT**

AGREED PLAN OF ACTION
Resident has a severe hearing impairment and sight problems. They cannot watch TV or read a newspaper because of these. They do, however, enjoy attending entertainment, especially those involving music and singing. Offer/provide regular opportunities for resident to mix with others and attend entertainment or activities wherever possible and appropriate. Resident is especially fond of singing – though they are not a great singer! Ensure those providing entertainment are aware of resident hearing and sight problems. Encourage resident's family to visit them regularly and involve them in family affairs wherever possible.

Routine Review Due monthly
Sign: .... **Date: ....**

Appendix 8: Manual Handling Profile

MANUAL HANDLING PROFILE

Date of Assessment: **Routine Review due:**

NAME	
D.O.B.	
UNIT	
ROOM No.	

BODY SHAPE			
HEIGHT		**WEIGHT**	
TALL		OBESE	
MEDIUM	✓	AVERAGE	✓
SHORT		THIN	

ABILITY TO COMPREHEND	
ALWAYS	
SOMETIMES	✓
UNABLE TO	

ABILITY TO CO-OPERATE	
ALWAYS	✓
SOMETIMES	
UNABLE TO	

SKIN CONDITION	**ADDITIONAL RELEVANT INFORMATION**
GOOD	Skin condition generally good.
POOR	
SKIN BREAKDOWN	

HANDLING CONSTRAINTS
Resident is very deaf but usually copes well. (They have refused a hearing aid in the past on several occasions.) Resident walks well using their Zimmer frame on and off the unit. They may require one carer to push them in a wheelchair, if they travel out of the home or if they are acutely unwell.

CAPABILITY	ASSISTANCE REQUIRED	No. OF STAFF REQUIRED TO ASSIST
SITTING UP IN BED	Nil Resident can sit up	Nil
MOVING UP THE BED	Nil Resident is independent	Nil
MOVING DOWN THE BED	Nil Resident can move down the bed	Nil
TURNING IN BED	Nil Resident can turn in their bed	Nil
TRANSFER FROM BED	Assist resident to swing their legs over the side of the bed Use one person to assist with standing up and give the resident their Zimmer frame.	1
STANDING	Ensure resident's Zimmer frame is close to hand. They can usually stand independently From very low chairs, use one person to assist with standing up and give resident their Zimmer frame.	1 (low chairs only)
WALKING	Resident usually walks well with their Zimmer frame and rarely needs supervision	1 (rarely)
TRANSFER CHAIR TO WHEELCHAIR ****** use wheelchair only for off-unit transportation or unless resident is acutely unwell***	Resident will stand and transfer independently using their Zimmer frame. One carer needed to position and push the wheelchair.	1 (rarely)
TRANSFER WHEELCHAIR TO CHAIR	Resident will stand and transfer independently using their Zimmer frame One carer needed to steady and remove the wheelchair.	1
TOILETTING	Resident will transfer independently into the toilet. Use one person to assist them to stand up, to help them off the toilet and to give them their Zimmer frame.	1
COMMODING	Resident does not usually use a commode. They prefer to use the toilet. Transfer as for toileting if required.	1 (rarely)
BATHING	Resident usually prefers to shower, but if they are unable to bathe then the Parker bath should be used. They can usually walk and transfer independently to the bath. One carer is needed to assist resident to lift their legs up into the bath.	1
SHOWERING	Resident will transfer independently using their Zimmer frame to their bathroom and transfer to the shower seat. They will need one carer to help them off the (low) shower seat and to return their Zimmer frame after their shower.	1

Appendix 9: Anonymised patient record

Date of Admission ....

RESIDENT DETAILS

Name *John Smith*

Date of Birth *8/9/17*

Previous Address

Marital Status *M*

Religion *Quaker*

Occupation *Lecturer*

GP *Smith*

Surgery *New Earswick*

Telephone No.

Next of Kin *Wife - Eleanor*

1.

Tel. no.

2.

Tel. no.

Past Medical History

1998 - Knee replacement

Parkinsons disease

Glaucoma

Transient ischaemic attacks

(Full medical history in Drug Medication Records)

Past Social History

Lecturer in Mathematics

Spectacles *Yes*

Walking Aid *Frame 2 Walkingsticks*

Hearing Aid *No*

Dentures *No*

Continence Aids *No*

Prosthesis & Appliances

Social Activities

Regularly visits coffee shop for meals with his wife

Allergies

Likes/Dislikes

Mother Tongue

NAME John Smith

CARE PLAN

DATE	DOMAIN NO.	PROBLEM	INTERVENTION	SIGNATURE
20.12.2001	5, 6, 16	Personal Hygiene	Assisted by 2 carers to wash and dress each morning and to get ready for bed each evening.	
			Encouraged to help himself where possible to gain some independence.	
			Incontinent at times, therefore pads are worn but he is toileted using the hoist.	
			Skin problems treat with appropriate creams.	
	5.	Immobility	Needs encouragement to mobilise but has freezing episodes due to Parkinsons. Hoist used when not able to walk.	
	12, 5, 14.	Nutrition and rehydration	Encouraged with diet and fluids to help with skin problems and current infection.	
			Taken to the coffee shop in a wheelchair when he wants to eat there with his wife.	
	7, 4, 10.	Communication and social interaction	Wife visits every day from the bungalow.	
			Encouraged to attend social events within the community.	

NAME John Smith

PROGRESS REPORT

DATE	DOMAIN NO.	COMMENTS	SIGNATURE
8.01.02	AM.	Assisted with washing and dressing, taken down to music and movement class at 10.30, staying down for dinner in the coffee shop.	
9.01.02	AM.	Assisted bed bath given, groin areas creamed. All cares given. Taken to the coffee shop for lunch.	
9.01.02	NIGHT	Assisted to the toilet during the night. Bowels well open-loose.	
11.01.02	AM.	Assisted with washing and dressing, used the maxi hoist to get to the bathroom. Transferred with 2 carers into the wheelchair. Bowles open, looks like some discharge as well as faeces, nurse informed.	
	PM.	Bowels well opened.	
13.01.02	AM.	Hoisted to the toilet, assisted with washing and dressing, finger nails clipped. Hoisted into his comfy chair.	
14.01.02	AM.	Hoisted to the toilet. Gave him a good wash and dressed him. All cares attended to. Quite cheerful.	

PART II

Flexible skills mix
A model of staffing for a new care development

Phillip Borkett and Jan Gilbert

1 Background

The project was designed to consider a model of staffing for Bedford Court, the new mixed development in Leeds. This will be registered by the Care Standards Commission (CSC) as a 'single home' without the former labels of nursing/ residential. It therefore provides scope for some more flexible and creative thinking about the deployment of staff and the link between resident need and staffing mix/levels.

An advisory group was formed in September 2001. Membership included registration and inspection officers from Leeds health and social services (incorporated into Care Standards Commission in April 2002). Other members were drawn from external care providers and Joseph Rowntree Foundation (JRF) staff. The group was chaired by the Director of Care Services and facilitated by an external consultant. The task of the group was to consider a model for the care needs of residents using the Minimum Data Set (MDS) Resident Assessment Instrument and the Home Care version to ascertain the care needs of residents. This is in turn related to the mix of staff who are required to plan and deliver care at the appropriate level.

The resulting model is to consider the types of qualifications that would be required to deliver safe and person-centred care. The project had links with other strands of JRF work including the development of the nurse practitioner role, the implications of single assessment and the continuing development of MDS.

Construction work on Bedford Court began in spring 2002. The development comprises 34 single en-suite rooms, four double close-care apartments (registration for 42) and ten bungalows. There will be flexibility to use the accommodation to meet specialist needs in the future. It is expected that there will be integration between the care home and bungalows from the outset.

The project has been informed by research carried out by Dr Iain Carpenter who has been looking at the use of MDS to identify nursing care in UK nursing homes (Carpenter and Perry, 2001). Part of the study involved a workload analysis of JRF homes. A further independent study of nursing time as related to resident dependency in JRF homes was undertaken in September 2002 for comparison (Appendix 2). Contact has been established with the Residential Forum (RF) which has been commissioned by the Department of Health to develop a formula for non-nursing staff levels in residential care. Finally, there has been considerable input from analyses of MDS data for existing JRF homes and discussions between the project consultant and home managers.

It was agreed that the project aims were to develop a model for the staffing of a 'single care home' which:

- ensures that residents have access to staff who are appropriately skilled to deliver the assessed care which will ensure their maximum quality of life
- establishes a link between resident dependency and staff establishment
- ensures that staff are deployed efficiently so as to utilise the skills, qualification and experience of each individual for their own and the home's benefit
- meets the requirements of the Care Standards Commission whilst offering a flexible and responsive approach
- meets JRF financial requirements by delivering a cost-effective, quality service.

2 Emerging factors

The project has been undertaken at a time of change and is seeking to take advantage of fresh thinking and new approaches to the registration, inspection and delivery of care for older people. Some of the most relevant issues are listed below in order to give an appropriate context.

The Care Standards Act, regulations, minimum standards and Commission

Since the project started the foundational documents have been finalised and CSC staffing put in place. The project has considered the relevant sections of regulation and minimum standards. Recent months have seen the relaxation by government of some proposed standards as exemplified in a letter from Jacqui Smith, Minister of State, to Ann Parker, Chair of CSC, which states *inter alia*, 'Essentially the Department is keen to ensure that your activities lead to the raising of standards, but that initially a pragmatic but timed approach is taken with regard to compliance' (National Care Standards Commission, 2002).

Recruitment of staff

This continues to be a problem across all care and health sectors. The Joseph Rowntree Foundation's experience is that the recruitment of professional staff, especially nurses, has proven particularly difficult in the Yorkshire region with both Lamel Beeches and Hartrigg Oaks having unfilled registered general nurse (RGN) vacancies.

Single care home

To date, there has been no guidance forthcoming on the way in which a home that provides both nursing and residential care will be regarded by registration and inspection staff. There have been developments on the single assessment process with detailed guidance issued by the Department of Health (DoH) along with identification of a number of suggested assessment tools (including MDS). The link between single assessment and a single registration is of crucial importance but it is still not clear how individual homes will be expected to specify the specific client groups they will care for. The most recent definitive paper on this subject was published by Malcolm Johnson and Lesley Hoyes for JRF in November 1996. This argued for a model which included 'A level and mix of staffing in each home dependent upon the assessed levels of need of residents' (Johnson and Hoyes, 1996, p. 3).

MDS

The Joseph Rowntree Foundation's experience of using MDS is evolving; all homes are now completing assessments and these are being used to establish the appropriate Resource Utilisation Group (RUG) and case-mix index. The Home Care version is being piloted at Red Lodge. As a general rule, this work is showing that MDS provides a useful tool to plan and monitor the care of individuals and the way in which resources are deployed between residents of differing abilities.

Refinements are ongoing in order to establish the most appropriate definitions of nursing and residential care. A recent development has been to equate RUG-III groups with the categories currently in use when Primary Care Trusts are calculating the Registered Nurse Care Contribution (RNCC) appropriate for individual residents in long-term nursing care (see Part I of this report).

3 Issues considered by the group

Skill mix

JRF dual-registered homes' staffing arrangements are similar to those found in most establishments of this nature. The home manager (registered nurse) usually works 'office hours' Monday to Friday. During the daytime shifts there will be one senior care assistant and between two and five care assistants depending upon the needs at particular times of the day. One or two care assistants work with a nurse to provide cover at night. Home management staff are on call at home if there are any emergency situations. There is flexibility to vary shift lengths and request additional hours to deal with exceptional dependency but temporary workload pressures are normally managed within the existing budget.

The role of a nurse working in a care home setting brings some tension. Some of these were

identified by the Iain Carpenter research where RGNs were interviewed by researchers. They have been confirmed in discussion with JRF home managers.

- It is universally agreed that procedures relating to complicated dressings, controlled drugs and taking blood requires a trained nurse. In a dual home some care staff defer to a nurse on decisions which would be taken by staff in a residential home without recourse to a nurse.
- The senior care role in a dual-registered home is often underdeveloped.
- Nurses in dual homes can often feel under pressure to 'nurse' residential clients.
- Nurses are trained to provide holistic care; whilst much of their time may be spent doing 'care' rather than 'nursing' duties they see this as part of the role – this has the potential for conflict with care assistants.
- A corollary to the above should be more opportunity for care assistants to offer social or emotional care, but there is often insufficient time for this.
- There has been a requirement that a nurse should be the manager of such a home but this may not always be the most appropriate use of skills.

Stephen O'Kell has suggested that an enhanced role for care assistants working in homes that provide nursing is wholly appropriate. It is recognised, however, that the success of this approach will depend upon the acceptance of care support workers undertaking extended care roles by registration units, the promotion of specific, extended care roles for support workers by home managers and the willingness of homes and members of the primary care team to provide the necessary training and supervision to care support workers undertaking these roles (O'Kell, 2002).

What do staff actually do?

Alongside this project the Joseph Rowntree Foundation commissioned a study to look at the work actually carried out by nurses, senior care staff and care assistants over a 24-hour period. In addition to the study carried out by Jan Gilbert (Appendix 2), staff working at Hartrigg Oaks kept a log of their work with individual residents. Staff time was logged by grade (e.g. registered nurse) and analysed against the individual RUG group. It was clear that this study mirrored the original work done for the RUG-III report (Carpenter and Perry, 2001). The report notes that whilst nurses are occupied positively throughout the day, their roles have become task-orientated, working on expected patterns to fit the residents' day. This appears to be around medication and some work with complicated dressings so much of their time was taken up by tasks which would ordinarily be performed by senior care staff or care assistants. The report concludes that whilst clearly providing quality care and supporting members of the team, much of the work undertaken by nurses could reasonably be undertaken by senior care staff. This is particularly evident between midnight and 6 a.m. as there were no essential nursing tasks performed for those residents designated 'nursing'.

Taking these comments into account the matrix shown in Table 1 has been used as the basis for an allocation of staff responsibilities at Bedford Court. The matrix shows the key tasks involved in delivering care according to dependency levels derived from the RUG analysis. The responsibilities indicated assume that the overall responsibility rests with the general care manager; clinical accountability is to the clinical manager. (These roles are further described in the section 'Towards a staffing model for Bedford Court' below.)

Table 10 Allocation of staff resources at Bedford Court

RUG-III group/care category	Assessment/planning/ monitoring of care	Delivery of care
Reduced physical function	Senior care	Care
Behavioural problems and above – care tasks	Senior care	Care
Behavioural problems and above – nursing tasks	Clinical manager	Nursing / specialist nursing staff
EMI care	Clinical manager / specialist nurse	Specialist care / Specialist nursing staff
Domiciliary / bungalow – care tasks	Senior care / domiciliary organisation	Domiciliary worker
Domiciliary / bungalow – nursing tasks	Clinical manager / district nurse	Specialist nurse or district nurse

Dependency and staffing

As part of the development of national minimum standards the DoH has commissioned the Residential Forum to conduct research and propose a formula which could be used by home owners and the CSC to calculate the staffing requirements for a given home. Guidance was issued to CSC offices in May 2002 (Department of Health and Residential Forum, 2001).

For existing homes, the staffing levels were to be maintained at 31 March 2002 levels until March 2003. It is accepted that the staffing levels required under the previous regime 'will normally have been appropriate'. Homes were asked to complete a questionnaire for analysis to the Residential Forum. For all new applications, the CSC will use the Residential Forum guidance which is described by the CSC as 'a robust and flexible approach to staffing numbers' and is primarily based upon the estimated number of care hours required for residents within three levels of dependency. The CSC recognises that the approach will not be suitable for every new home; it will therefore be flexible and recognise that 'some care homes will have legitimate reasons for establishing alternative staffing levels'(National Care Standards Commission, 2002).

The present guidance does not cover nursing staff and it is not yet clear how the formula will assist in calculating the mix of staff needed in homes that offer both residential and nursing care. There are some concerns in the independent sector that the formula may create unrealistically high staffing requirements and this indeed was experienced recently at one of the Joseph Rowntree Foundation's care homes.

The Residential Forum formula takes into account:

- dependency (high is 20 hours per resident / week, medium is 18, low is 16), although there is no developed tool to assess and measure high, medium and low dependency
- 'overheads'
- building layout if this is difficult
- staff training
- social, cultural and recreational needs of the residents
- implications of moving and handling.

The flexible skills mix project envisioned a situation whereby information from MDS (RUG-III group) will help to determine the numbers of staff

and the mix of staff types that will be appropriate to meet the needs of residents of Bedford Court at a given point in time. This is rightly seen as the key to the whole issue. In order to arrive at an appropriate formula considerable work has been done by JRF colleagues and the project consultant in an attempt to link MDS data with information on staffing levels in existing homes and the expert advice of home managers.

Nursing/care balance

As indicated above there are some issues about the role of nurses in care homes and questions over the best way of utilising experience and training. JRF is exploring the role of specialist nurses and already employs a registered mental nurse (RMN) who works across the organisation, supporting staff and residents in the care of people with dementia. It is suggested that general nurses could work in a similar fashion by providing specialist nursing care (e.g. dementia, pressure areas, continence, diabetes, nutrition). This would leave the trained care staff to handle care tasks. The extent to which this role would be attractive to staff and residents is still to be explored but it appears to make effective use of a scarce resource.

There are questions about the inevitability of home manager positions being filled by a registered nurse. Management and administration may not be the most appropriate task for those who have comprehensive clinical training (and indeed this may not always be the preferred career path of the individuals concerned). There is however, a role for a properly trained general care manager to have overall responsibility for a development such as Bedford Court.

It follows that the need for a nurse to be in attendance on a 24-hour basis is not automatic where a home adopts a true resident-centred and dependency-led approach. It is considered that the following elements should be present for such an approach to be considered:

- the effective use of an agreed common assessment instrument (e.g. MDS, EASY-Care)
- staffing arrangements linked to dependency (e.g. RUG-III)
- a tightly defined management structure
- a commitment to effective team working
- an enhanced role for care and senior care staff
- the involvement of specialist nurses
- a robust approach to monitoring and evaluation.

Working together, these elements should create a responsive and flexible structure that is of greatest benefit to the residents.

4 Towards a staffing model for Bedford Court

Taking the foregoing factors into account the following principles have been established:

- Overall management of the project will be the responsibility of a general care manager who will have experience and qualifications in both care and general management. He or she will be required to hold the Registered Manager's Certificate as required by CSC and may be a nurse but this will not be a primary requirement.
- A clinical manager will be responsible for assessment and monitoring in relation to nursing needs and will manage the deployment of nursing staff according to the dependency of residents. He or she will be a first-level registered nurse.
- The role of care staff will be enhanced in accordance with the matrix above (Table 1). A

senior care worker will act as team leader for each shift and will be qualified to NVQ 3 or 4. Care staff will have achieved or be working towards NVQ 2 in accordance with the Care Standards Act.

- Therapy staff (such as occupational therapists and physiotherapists as well as activities specialists) will be engaged for sessional work, as identified in the resident assessment.
- Care and nursing staff complements will be based on assessed resident need. A formula has been developed that is based upon the Residential Forum guidance in respect of care hours. There will be an additional allocation for nursing hours based on the appropriate RUG-III group. The hours allocated to each group will be derived from independent research (see section 5 and Appendix 1).
- There will be a number of core nursing hours employed in order to carry out essential nursing procedures. Other nurse hours will be co-ordinated by the clinical manager and may include input as appropriate from general and specialist nurses in continence, dementia, diabetes, pressure and nutrition.
- Domestic, kitchen and maintenance staff will be expected to adopt a person-centred approach to their work and be working towards appropriate qualifications. Flexibility and team working will be key attributes.
- The model will be subject to detailed independent evaluation and monitoring.

5 The model

Two examples for theoretical homes are given in Appendix 1 – Table 11 shows the staffing calculations for a lower-dependency home and Table 12 shows the calculations for a higher-dependency home.

Part A uses information from the independent study to derive a formula for the number of nursing hours needed in a week for residents in the three most prevalent RUG-III groups (clinically complex, behaviour problems and impaired cognition).

Part B is used to calculate the number of care and nursing staff needed for a given resident profile. Residential hours are based on the dependency allocation in the Residential Forum model. The basic hours are increased for social, recreational and cultural needs and staff training (based on Residential Forum formula); this gives a revised total of care and nursing hours required for a period of seven 24-hour days).

Part C indicates an approach to the distribution of these hours. The model assumes the following 'fixed' staffing arrangements: one senior care worker on duty 24 hours a day (three shifts) and two care workers on duty at night. The figure for 'nurse days' is brought forward from part B (total nurse hours). This is a balancing figure to provide staffing to the revised total in part B. (In all cases figures have been rounded to whole numbers.)

Finally, additional hours are added for the general manager and clinical manager. It is assumed that the clinical manager will be able to offer two shifts of 'hands on nursing' per week. The total number of nursing hours available in the week is expressed in terms of the total number of nursing hours available over a 24-hour period. It should be noted that 'nurse days' are expressed in terms of regular shift patterns but these hours will be available for flexible use according to the needs of residents. The clinical manager will be responsible for deploying these.

References

Carpenter, I. and Perry, M. (2001) *Identification of Registered Nursing Care Time for Residents of UK Nursing Homes using the Minimum Data Set Resident Assessment Instrument (MDS/RAI) and the Resource Utilisation Groups (RUG-III) Resource Use Casemix System*. Canterbury: University of Kent, Centre for Health Service Studies

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Department of Health and Residential Forum (2001) *Staffing the Standards: Minimum Staffing Levels of Non-nursing Staff in Residential Care Homes for the Elderly*. London: Department of Health and Residential Forum

Johnson, M. and Hoyes, L. (1996) 'Establishing a regulatory system for single registered care homes', JRF *Findings* H200, November

National Care Standards Commission (2002) 'NCSC provides guidelines on staffing levels in Care Homes', press release, 2 May

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Appendix 1: Staffing calculations for Bedford Court

Example calculations derived from staffing formula using Minimum Data Set (MDS) Resource Utilisation Groups (RUG)

Table 11 Lower overall dependency

Part A Nursing time required

	RGN mean mins observed in 24 hours			Total mins	Total hrs
	Direct care	**Indirect care**	**Total mins**	**per week**	**per week**
Clinically complex	34.3	12.6	46.9	328.3	6
Behaviour problems	28.0	5.1	33.1	231.7	4
Impaired cognition	23.1	4.4	27.5	192.5	3

Source: Carpenter and Perry, 2001.

Part B Calculation of staffing hours for Bedford Court

Dependency (RUG-III group)	Number	Nurse hrs (from above)	Care hrs (Res. Forum)	Total hrs nurse	Total hrs care	Total hrs per week
Clinically complex	4	6	20	24	80	104
Behaviour problems	2	4	18	8	36	44
Impaired cognition	2	3	16	6	32	38
Residential	34	0	16	0	544	544
Total	**42**			**38**	**692**	**730**
Add social, recreational, cultural at 1% total budget				7		
Plus fixed allowance of 15 hrs				15		22
Add staff training at 2.7%						20
Revised total						**772**

Part C Distribution of staffing hours

Staff	Shifts per day	Shift length	Hours per week
Senior care days	2	7.5	105
Care days	8	7.5	419
Nurse days	1	7.5	38 for flexible use
Senior care nights	1	10.0	70
Care nights	2	10.0	140
			772
Home manager	1	7.5	37.5
Clinical manager	1	7.5	37.5
Total hours required			**847**
Care manager			37.5
Clinical manager	Management	22.5	
	Nursing	15	37.5
Nursing			38
Senior Care			175
Care			559
			847

Nursing staff available in a 24-hour period: 8 hours

Table 12 Higher overall dependency

Part A Nursing time required

	RGN mean mins observed in 24 hours			Total mins	Total hrs
	Direct care	Indirect care	Total mins	per week	per week
Clinically complex	34.3	12.6	46.9	328.3	6
Behaviour problems	28.0	5.1	33.1	231.7	4
Impaired cognition	23.1	4.4	27.5	192.5	3

Source: Carpenter and Perry, 2001.

Part B Calculation of staffing hours for Bedford Court

Dependency (RUG-III group)	Number	Nurse hrs (from above)	Care hrs (Res. Forum)	Total hrs nurse	Total hrs care	Total hrs per week
Clinically complex	16	6	20	96	320	416
Behaviour problems	8	4	18	32	144	176
Impaired cognition	8	3	16	24	128	152
Residential	10	0	16	0	160	160
Total	**42**			**152**	**752**	**904**
Add social, recreational, cultural at 1% total budget				9		
Plus fixed allowance of 15 hrs				15		24
Add staff training at 2.7%						24
Revised total						**952**

Part C Distribution of staffing hours

Staff	Shifts per day	Shift length	Hours per week
Senior care days	2	7.5	105
Care days	9	7.5	485
Nurse days	3	7.5	152 for flexible use
Senior care nights	1	10.0	70
Care nights	2	10.0	140
			952
Home manager	1	7.5	37.5
Clinical manager	1	7.5	37.5
Total hours required			**1027**
Care manager			37.5
Clinical manager	Management	22.5	
	Nursing	15	37.5
Nursing			152
Senior care			175
Care			625
			1027

Nursing staff available in a 24-hour period: 24 hours

Appendix 2: Nurse monitoring activity over a 24-hour period

Summary
In the light of the changes within the care standards, the limited number of nurses available and the developments in care staff education and development, a more flexible approach to staffing should be considered.

Within The Oaks it was evident that over the 24 hours observed, it was the team who, through their knowledge and skills, ensured the quality of care. Whilst there can be no doubt that the knowledge, skills and ability of nurses are an essential element, this study cannot demonstrate that there is a need for a 24-hour nursing presence in this establishment with the current skill mix and client group.

Background
In line with the project purpose – to enable the development of a model for staffing the Bedford Court establishment – it was agreed to monitor nursing activity over a 24-hour period at The Oaks in York. In the light of the new care standards and the registration of establishments as residential homes without the former labels of nursing/ residential there is scope for more flexible and creative staffing matrices that better meet the needs of the client and the organisation, as well as taking into account the knowledge, skills and ability of the various team members.

In assessing the activities undertaken by the nurses whilst on duty it was felt appropriate *not* to identify specific patients as the senior person on duty had a holistic role to ensure care was delivered appropriately to the whole of the client group. The analysis therefore considers not only the actual 'nursing' activities undertaken but also the non-nursing functions inherent in the role.

This report is therefore to be considered as one aspect of the overall project and should not be taken out of context.

In accordance with the new care standards (Department of Health, 2000), Standards of Care for Older People and Clinical Governance, all decisions should be based on accurate and up-to-date evidence. This study complies with this requirement in that the report relates to actual care delivered in the period identified and has been analysed within a setting that holds current accurate data on client-assessed needs as based on the RUG-III system (Carpenter and Perry, 2001).

Methodology

Monitoring of the nurse on duty
It was agreed that the activities undertaken by the nurse on duty would be monitored over a 24-hour period. Activities were monitored in one-hour chunks with the data being collapsed into more meaningful periods as activities were determined. It was intended to use a pre-existing proforma (Appendix 1) as this had been used in the development of the MDS data sets. Additional information was to be recorded separately on the same record sheets. There was only one person monitoring the activities over the period agreed to ensure consistency of data collection.

Team information
All team members were advised of the purpose of the project, with special emphasis that:

- the resultant data was to be used for the new Leeds-based establishment
- the data were not to be linked to any one nurse's activity and therefore were not to be viewed as an individual/personal review
- the staff were to be introduced to the researcher by the project director and the home manager.

Furthermore, the skill mix of the team on duty was identified as a means of conceptualising the nurses' workload and their actual activities.

Gap analysis
In addition to the acknowledgement and analysis of the data in respect of what was observed activity of the nurses, analysis of what was not observed activity and yet could be considered integral to the effective management of the shift will be analysed to ensure that a comprehensive and explicit review is presented.

As noted by Carpenter and Perry (2001), decision making is a key part of the nurses' role but is difficult to quantify and not always available for observation.

Skill mix
The staffing levels for The Oaks is as detailed below. This complies with the current staffing notice and does not include the senior nurse manager, other management, or administrative or cleaning/domestic staff who were on duty at the time.

The complement of staff below was for 42 clients with a mixed economy of care including 14 nursing and 28 residential clients. All clients were considered 'long-standing' clients with no new admissions during the last week being reported.

Night staff – 9.30 p.m. to 7.30 a.m.

RGN	×	1
Care staff, NVQ 2	×	1
Care staff	×	1

Morning staff – 7.15 a.m. to 3 p.m. (Staff starting times were staggered over the first two hours of the morning with the full complement of staff being on duty by 8.30 a.m.)

RGN	×	1
Senior care, NVQ 3	×	2
Care staff	×	3
Supernumerary	×	1 student nurse

Afternoon staff – 3 p.m. to 9.15 p.m.

RGN	×	1
Senior care, NVQ 3	×	1
Care, NVQ 2	×	1
Care	×	2

Data collection

Data collection limitations
Over the 24-hour period the researcher was present on the unit for 21 of those hours. The time not present included a 2.5-hour rest period between the hours of 02.30 and 05.00 when the staff nurse agreed to self-monitor care activities, two meal breaks taken in the canteen of 20 minutes and a ten-minute comfort break. During one of the meal breaks the nurse in charge accompanied the researcher; during the other break the nurse reported that she would be taking a break and then self-reported activities that had then been undertaken during the researcher's absence.

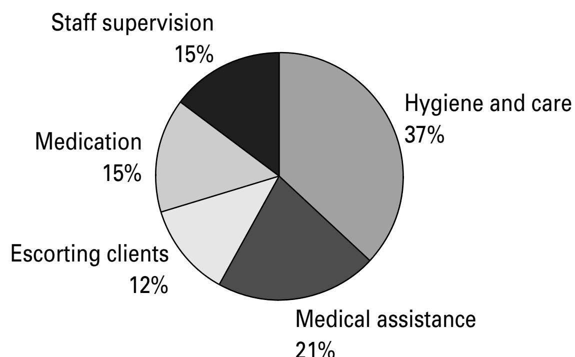
Although the researcher is a qualified nurse, she was not present in the rooms when personal care was being delivered. This was felt to be too intrusive and unnecessary.

Data analysis
Monitoring commenced at 22.00 on 26 September 2002 and continued for the following 24 hours. The following figures show the activities undertaken by the nurse during each of the periods shown.

The figures do not show the activities undertaken by other members of the team, however additional notes are made where appropriate.

Period 1 – 22.00 to 23.00
During this period clients were settled for bed by all members of the team. The nurse on duty also escorted the doctor who was visiting a client deemed to be in need of medical review.

Figure 3 Nursing activity, 22.00–23.00

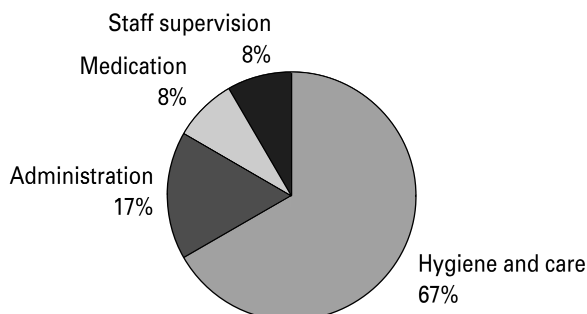


As can be seen, for the first hour, the majority of the time involved direct client care. Fifteen per cent of the first hour involved administration of medication – all of which were oral. The doctor gave the one injection required by the client he visited.

Period 2 – 23.00 to midnight

Care continued during this time at the specific request of some clients (i.e. requesting sleeping tablets); the staff nurse also completed 'domestic' checks, e.g. fire reports and security checks. One client alone did take up a significant amount of time (25 minutes) but this was for general rather than specific nursing care.

Figure 4 Nursing activity, 23.00–midnight

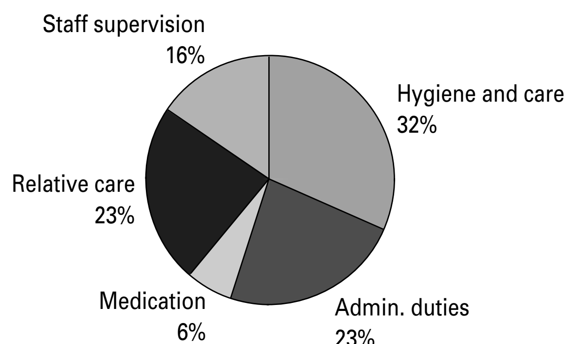


Period 3 – midnight to 01.00 (27 September)

As one would expect, the majority of the clients had settled by this time. The staff nurse spent 15 minutes with the daughter of the client seen by the doctor and continued to administer medication (analgesics) as requested by the clients.

Staff on duty communicated with the staff nurse in a continuous informal manner but a more formal résumé was given as staff congregated for a drink at approximately 00.30.

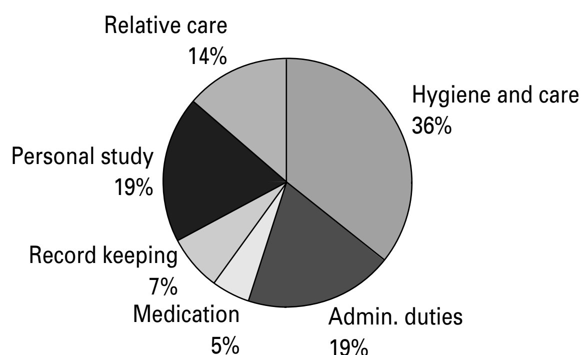
Figure 5 Nursing activity, midnight–01.00



Period 4 – 01.00 to 05.30

As one would expect, this time period was relatively quiet. The daughter of one client was still present and staff spent 28 minutes reassuring the lady that all care possible was being afforded her father. Care of the remaining clients continued in a planned manner in the form of 'rounds', with additional care being provided as requested by clients. The staff worked as a team with care being provided by the team with no apparent differentiation as to the category of client (nursing or residential) and the two 'rounds' were completed in 35 minutes on each occasion. Medication was administered by the nurse, this being analgesia predominantly in the form of paracetamol tablets. During this time the administration of medication accounted for ten minutes. There were no injections administered during this time.

Figure 6 Nursing activity, 01.00–05.30



Household duties (setting tables and trays and monitoring fridge temperatures) were carried out as a team effort and accounted for 40 minutes of the nurses' time. In addition the staff nurse had brought materials to study that were for a care-related course she was on. The nurse took the opportunity to discuss her progress on the course with the researcher: this accounted for approximately 40 minutes of our time. During this time the care staff did answer client calls. Staff reported that she continued to study during the researcher's break.

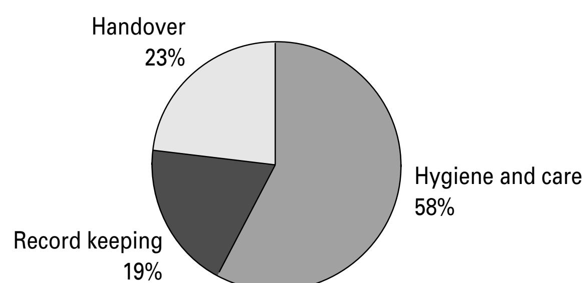
Administrative duties were also carried out (record keeping), but staff reported that this was not particularly onerous on that shift as the care plans for her specific clients had only recently been updated and the client's status had not changed significantly in the intervening period. This took 15 minutes.

During this time one client was found on the floor but was deemed not to have suffered any injury and was assisted back to bed after being assessed by the nurse (seven minutes). Normal reporting of accidents was completed by the staff nurse.

Period 5 – 05.30 to 07.30

Again, as would be expected, this was a period of increased activity. Because they were an experienced team there was no significant time spent directing the care staff as to their duties. The staff nurse made a personal 'round', checking on all clients, and completed the care reports prior to handover. No morning medication was given by the night staff and the only significant event was that a client was found on the floor but this was dealt with by the care staff initially with the staff nurse checking the client following the delivery of care. Client care accounted for 45 minutes; record keeping accounted for a further 15 minutes with 18 minutes being taken up giving a report to the day staff.

Figure 7 Nursing activity, 05.30–07.30



Period 6 – 07.30 to 11.00

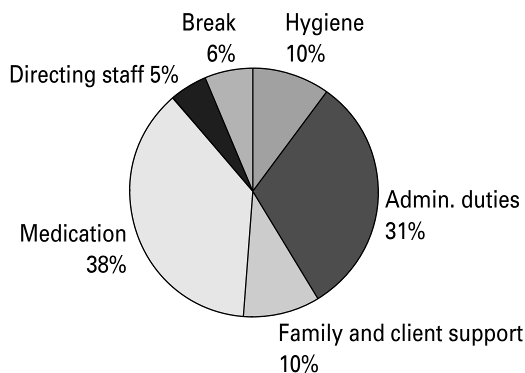
This period begins at the beginning of the shift to the official break time of 11.00. All of the day staff took the report together from the night staff team. Team members' workload was pre-prescribed according to experience and qualifications and this was apparently detailed within a workbook. Having taken the report the team dispersed and went about their duties without the apparent need for staff to direct them. Over the next three and a half hours the staff nurse went about her duties relatively independently. The rest of the team worked either independent of each other or in pairs. This related to the tasks they had to perform: for example, one senior carer allocated to the upper floor was dispensing medication to those clients identified as 'residential' with the staff nurse dispensing medication to all clients on the ground floor and to those clients identified as 'nursing' on the first floor. This did include the administration of two insulin injections and one controlled drug (MST). Included on the team was a second-year student nurse. She worked alongside different

members of the team and her activities were clearly co-ordinated by the staff nurse.

During the morning staff spent 17 minutes giving family support, 75 minutes on administrative/paper work/telephone calls, 90 minutes on the administration of medication, 24 minutes on direct client care and six minutes discussing with a client their medication administration and 12 minutes directing care staff.

At approximately 11.00 the team congregated in the staff room for a break for 15 minutes.

Figure 8 Nursing activity, 07.30–11.00

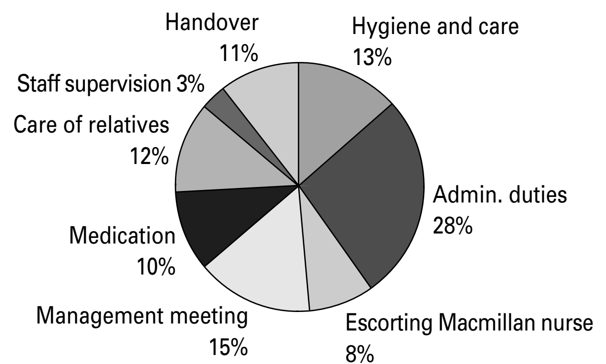


Period 7 – 11.00 to 15.00

The morning staff continued to provide care up until shift changeover at 15.00. At shift changeover the qualified nurse coming on duty overlapped with the morning staff and provided an escort to one client moving to another home within the locality. It was reported that whilst it was normal for a client to have an escort, it was not normal to provide qualified nurse escort unless the client's condition demands. On this occasion the condition did not warrant qualified nurse escort but staffing levels permitted this. As this was not deemed to be the norm this activity is not included in the analysis, which only records the activities of the nurse remaining on site.

Between the hours of 11.00 and 15.00 the staff nurse continued to work as a member of the team, predominantly administering medication as required by individual clients (21 minutes) and communicating with clients, relatives and visiting healthcare professionals. The staff nurse spent 17 minutes with the Macmillan nurse, 56 minutes undertaking administrative duties including report writing and 32 minutes in discussion with the Senior Nurse Manager on duty. A further 25 minutes involved talking with relatives. The care staff on duty served the meals and fed those clients needing assistance. Providing direct client care (hygiene etc.) took a total of 28 minutes with a further seven minutes being spent directing staff. Whilst the staff on duty did take a meal break at 'lunch' time, the staff nurse continued to work over this period answering calls, administering medication with meals and writing reports. Handover took place in the office and took 22 minutes. Other members of the team contributed to the handover, especially the senior care staff who reported on their clients specifically.

Figure 9 Nursing activity, 11.00–15.00



Period 8 – 15.00 to 18.00

Following handover, the team once again dispersed and went about their work with little obvious direction from the nurse in charge. Instructions were written in the workbook and the team clearly knew their roles and responsibilities. The staff nurse's first action was to 'tour' the unit, obviously checking on the status of every client (22 minutes). This time is combined with the direct care delivered. Once satisfied the staff nurse then spent time with the

Figure 10 Nursing activity, 15.00–18.00

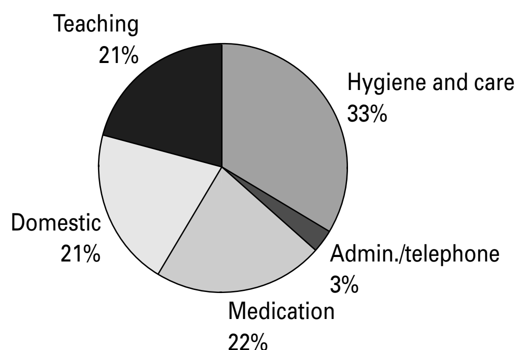
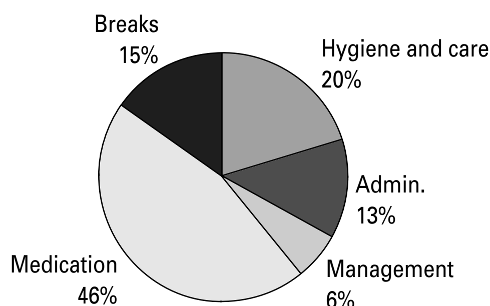


Figure 11 Nursing activity, 18.00–21.30



student nurse. As this was the student nurse's last day on the unit the staff nurse spent 35 minutes with the student completing her report. Administration of medication was undertaken by both the nurse and the senior carer (who was responsible for the care of the 'residential' clients on the first floor as in the morning). Administration of medication took a total of 37 minutes during this period.

Direct client care required 35 minutes of time with a further 35 minutes being taken up with domestic duties. As the senior member of staff on site, the staff nurse also gave telephone advice to the 'bungalow' staff (five minutes). Staff nurse assisted the care staff with the serving of the meals and this is included in the overall care time.

Period 9 – 18.00 to 21.30

The staff nurse continued to work with care staff overseeing the care delivered. During the evening period staff spent 40 minutes providing physical care with a further 90 minutes being taken up with the administration of medication. This included insulin injections (six minutes). Seven minutes were taken up with telephone calls and a further 12 minutes involved discussions with the senior manager on duty. The staff nurse spent approximately 18 minutes on report writing with the handover taking 20 minutes at the end of the shift. A total of 30 minutes was taken as breaks – these were taken with all members of the team.

Review

Throughout the period of observation the team consisted of experienced team members – experienced in the provision of care and knowledgeable in the needs and wants of this client group. There were a number of instances where staff were able to state what a client was calling for prior to answering the call bell.

The team were, relatively speaking, highly qualified. Care staff were reported to hold either an NVQ level 2 or 3 with senior care staff on day duty having completed the JRF Certificate in Care. One of the senior care staff is reportedly applying for a manager's position within a residential home. Colleagues report that, in their opinion, he has the knowledge and the ability to meet the role requirements. It was noted that, in respect of the 'residential' clients, their care needs were being met by the senior care and care staff allocated. Staff nurses all confirmed that care staff would refer problems to them should the need arise but, in the main, would 'get on with the job' without requiring direction.

It is clearly shown that the nurses are occupied positively throughout the day. Their roles, however, do appear to have become task-orientated, working to expected patterns to fit the client's day. This appears to be predominantly around the administration of medication, and yet other members of the team also perform this function. It is also clearly demonstrated that, as a team, this group of staff, either intuitively or through past

experiences, know their roles and responsibilities.

The care provided by this group is clearly of a high quality and the nurse call system in use enabled staff to be more efficient in their use of time – by being able to talk to clients directly when they call for assistance, staff are able to respond appropriately without having to walk to the client to ask what they want and as such the appropriate member of the team is able to respond immediately.

The nurses had obviously spent time and energy supporting and working with the student nurse and she reported this on a number of occasions. She was also able to report that she had been very well supported by the senior care staff, all of whom had gained her respect because of their knowledge and care practices.

Summary

Whilst clearly providing quality care and supporting members of the team, much of the work undertaken by the nurses could reasonably be undertaken by senior care staff. This is particularly evident after midnight up until 6 a.m. During this time in particular, for this client group, there were no essential nursing duties that had to be performed for those clients designated 'nursing', and the one client who required medical assistance was seen by a doctor prior to midnight following which his needs were met by all members of the team equally.

The safe administration of medication in this establishment is undertaken predominantly by the nursing staff, but senior care staff trained in the safe administration of medication do undertake this task for 'residential' clients – and in many cases the medication is the same for both nursing and residential clients. The administration of insulin does remain a nursing task and was undertaken accordingly.

There were no other significant nursing activities observed during this 24-hour period, with no wound care or other specialist care being required by clients at this time. Staff did report that they felt safer having a qualified nurse on duty and did express concern as to their own knowledge and experience should there be an 'emergency' or should a client's condition change.

In the light of the changes within the care standards, the limited number of nurses available and the developments in care staff education and development, a more flexible approach to staffing should be considered.

Within The Oaks it was evident that it was the team who, through their knowledge and skills, ensured the quality of care. Whilst there can be no doubt that the knowledge, skills and ability of nurses are an essential element, this study cannot demonstrate that there is a need for a 24-hour nursing presence in this establishment with the current skill mix and client group.

PART III

The specialist nurse project
Enhancing the quality of residents' care

Val Ellis, Chrysa Apps and Peter Cox

1 Background

This project forms part of the ongoing commitment to continuing evaluation and improvement in care to residents who live in homes run by the Joseph Rowntree Housing Trust (JRHT).

The Joseph Rowntree Foundation wished to explore the manner in which nurses and other staff with specialist qualifications and expertise can be deployed in innovative ways across care homes to enhance the quality of residents' care.

It was recognised that the needs of people living in residential and nursing care homes are complex and multifaceted, with medical, nursing, social, psychological and practical care needs which require a variety of input from professional staff including GPs, hospital consultants, nurses, community services, physiotherapists, occupational therapists, nutritionists, social workers and carers who all have roles to play if these complex needs are to be met. However, most care homes employ only carers and nurses although most have access to the other specialist services outlined above.

The Foundation has a small number of residential and nursing homes in and around York managed by the Joseph Rowntree Housing Trust. These care homes include provision for people with special needs such as learning and physical disabilities as well as older people.

JRHT employs 12 registered nurses across two of its care homes and many of the nurses already have expertise and specialist qualifications. One has experience of ENT (ear, nose and throat) and is interested in hearing loss problems, and another nurse has a diploma in diabetes care. It was decided to identify a specialist across as many client groups as possible for a pilot project where dementia and mental health issues were recognised as a major and growing problem for older people and those with learning disabilities. The problems of mental health and mental infirmity were already being identified using the Minimum Data Set (MDS) assessment tool, evidence from home staff and the growing body of published research into the increasing needs of older people.

A registered mental nurse, Val Ellis, was approached to see if she was interested in gaining extra skills and qualifications and applying these skills not only to the home where she was employed but also across all of the homes.

2 Project aim

The project aim was to identify how a specialist nurse could work across a group of homes. The key objectives were:

- to develop services for the support of individuals who have mental health problems and/or dementia, and for the support of the staff and carers
- to develop services for the support of people with learning disabilities who may have dementia and are not always in receipt of specialist nursing care
- to develop a model for specialist staff to offer advice and guidance across a group of care homes
- to set up training and development programmes across a group of homes to support people who have mental health needs and their carers
- to consider an assessment mechanism to determine the level of need of people in a residential, nursing and community setting.

Once the key objectives were agreed with senior staff of the Housing Trust a project advisory team was set up consisting of the following members:

Chrysa Apps	Practice Development Manager
Clive Bowman	BUPA
Maggie Coxan	Care Standards Commission
Peter Cox	Lecturer in Health Sciences, University of York
Sue Davies	Head of Home, Hartrigg Oaks
Cedric Dennis	Director of Care Services

Wendy Dixon	Care Standards Commission
Val Ellis	Specialist nurse
Jan Gilbert	Independent consultant
Amanda Kelsey	University of York
Alison Little	The Retreat

The project partners who would steer the project were Chrysa Apps, Val Ellis from JRHT and Peter Cox from the Department of Health Sciences at the University of York. Peter would provide support and mentoring to Val throughout the project.

The education and training needs of the project nurse, Val Ellis, were identified:

- a University of York continuing professional development module ('Mental health in old age')
- attendance at conferences and seminars including 'Dementia care 2000' and 'Dementia care 2001' at the University of Leeds
- 'Dementia care in the community' in Birmingham in association with the *Journal of Dementia Care*.

In 2002 she attended:

- 'Dementia training skills' with the Alzheimer's Society
- 'Dementia care 2002' in Bradford

Training events included:

- 'Moving from activities to person-centred occupation' with Dementia North
- carers' workshops discussing mental health services for older people with the Alzheimer's Society
- a dementia awareness training day
- 'Non-abusive psychological and physical intervention' in association with NAPPI UK
- 'Signs, symptoms and management of mental health problems in care homes' in association with Boots the Chemist
- 'Dementia and residents with learning difficulties' with Graham Stokes (Clinical Psychologist and Consultant Director of Mental Health to BUPA Care Services)
- 'Anxiety and adjustment in old age' with Graham Stokes.

The project nurse also visited The Retreat Hospital's Challenging Behaviour Unit to meet the staff and discuss their philosophy of care.

3 Implementing the project

It was decided to concentrate the first part of this project in the home where the project worker was initially employed. This is at Hartrigg Oaks at New Earswick near York. Work was also done at Red Lodge, Lamel Beeches (both for older people), Alder House (for people with cerebral palsy), Dormary Court, Charles Court and Fledglings Court (all for people with learning difficulties).

Hartrigg Oaks is the first continuing care retirement community in the United Kingdom. It was completed in 1998 and is situated in the village of New Earswick on the north side of the city of York.

The development consists of 152 one- and two-bedroom bungalows with 41 rooms in the care centre, called The Oaks. There are extensive communal facilities, including a restaurant, coffee shop, arts/crafts room, library, music room, spa pool/Jacuzzi, fitness centre and a small shop. The aim is to provide high quality accommodation and care services which meet the needs of older people (aged at least 60), ranging from independent living in their bungalow to full care and nursing support in The Oaks.

The Oaks offers both residential and nursing care, and is registered with the City of York Council and North Yorkshire Health Authority. It has 41 en suite bedrooms. The residents who live in the bungalows can, if necessary, take up residence at The Oaks if their health has declined to a point

where it is not possible to maintain independent living, even with the maximum care available in the Hartrigg community.

The project worker was enthusiastic to improve the assessment, care planning and education of staff within the organisation, trained and untrained, so that those residents with mental illness would receive the same level of skilled care as those with physical illnesses. The training had to include all sections of staff from ancillary staff to office staff as all come into daily contact with the residents.

In principle, the aim was to bring together the expertise available at Hartrigg Oaks and to combine this with input and support from the community psychiatric nurse (CPN), Linda Auer, who liaises with Hartrigg Oaks and University of York lecturers Peter Cox and Dr Amanda Kelsey. Latter stages of the project would include input from other CPNs working in the other homes.

A particular focus for the specialist nurse is the increasing need to respond to those residents presenting with dementia.

It was important to establish the anecdotal evidence of dementia within the various units managed by the Foundation, so informal meetings with the project worker and Peter Cox took place with the home managers where it became apparent that dementia was in evidence, with the following figures reported by nurses and other staff working directly with residents.

Anecdotal figures

- Lamel Beeches (nursing and residential home): 38 residents (19 identified with dementia)
- Red Lodge (residential home): 35 residents (12 identified with dementia)
- The Oaks (nursing and residential home): 41 residents (23 identified with dementia).

Assessed figures

The assessment tool used within the Joseph Rowntree Foundation is the Minimum Data Set (MDS). Using this tool, staff were able to produce a structured assessment of cognitive loss in residents and produced the following prevalence figures in April 2002. These figures show a close correlation with the anecdotal figures from the care homes:

- Lamel Beeches: 19 residents identified with cognitive loss
- Red Lodge: 20 residents identified with cognitive loss
- The Oaks: 26 residents identified with cognitive loss.

However, the degree of cognitive loss varied from resident to resident. The cognitive loss scale within the MDS tool has a seven-point scale describing cognitive loss.

The cognitive performance scale was developed to describe the cognitive status of an individual and is based on:

- short-term memory
- cognitive decision making
- making self understood
- dependent eating.

The team considered using the MDS mental health (MH) assessment tool which was being developed in the USA and Canada as a part of the overall assessment process to try and determine the level of mental health needs. However, MDS (MH) was aimed at the acute hospital sector and not specifically for those people with dementia and mental health needs of old age.

There is a need for a specialist dementia measurement tool either as part of the MDS family of assessment tools or as an independent measure. There was discussion within the team and the advisory group about developing such a tool but it was considered to be impracticable in the context of this project.

Figure 12 Cognitive performance scales: Lamel Beeches, April 2002

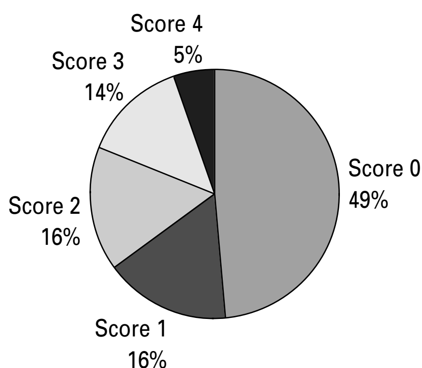


Figure 13 Cognitive performance scales: Red Lodge, April 2002

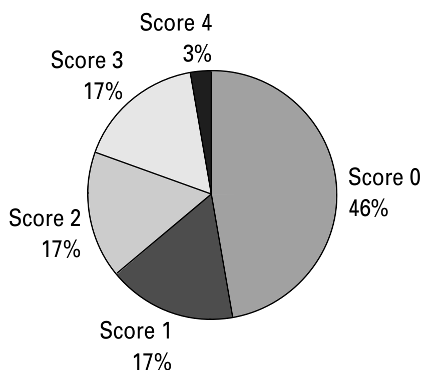
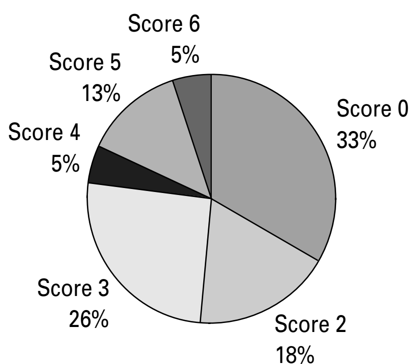


Figure 14 Cognitive performance scales: The Oaks, April 2002



(Score 0 = no cognitive impairment, score 6 = severe cognitive impairment)

Behavioural changes associated with dementia can cause carers to regard residents as 'challenging'. The concept of challenging behaviour is directly related to carer ability to respond appropriately: i.e. those who have the necessary knowledge, skills and attitudes to respond positively may perceive less of a challenge.

The challenge is often one which affects both the client and staff, impacting on the physical, emotional and environmental well-being of all concerned. Those clients with mental health needs were identified in order to establish met and unmet needs, and to prepare staff to respond therapeutically to both their psychological and physical care.
(Peter Cox, unpublished)

Case study 1

Brenda and her husband Jim retired to live near York until they were not able to cope any more due to failing ill health. They decided to move to Hartrigg Oaks at New Earswick in York where they took up residence in a bungalow where they lived independently with only minimal intervention from the care staff.

Over the months Brenda's mental and physical health began to deteriorate as she began to suffer more angina episodes which led her to panic and repeatedly summon help from the care centre during the day and night when she needed much reassurance. It became clear that she and Jim were not managing as well as they had been and they were losing confidence. We began to give more assistance to the couple in the bungalow in the form of cleaning etc. and assistance with Jim's care, i.e. getting up, bathing, dressing and putting to bed at night and for a short time this helped and they continued to live in their bungalow.

continued

In 1999 Brenda had several admissions to hospital having suffered a CVA [cardiovascular accident] and various other physical health problems which led to a severe deterioration in her overall physical and mental health including confusion, disorientation, paranoia and memory difficulties. Whilst in hospital Brenda was assessed and diagnosed as suffering from depression with a possible toxic confusional state.

After treatment it was decided by medical staff, the carers at Hartrigg Oaks and the couple's sons and husband that a return to the bungalow would be impossible. Brenda returned to Hartrigg Oaks and she and her husband took up permanent residence in The Oaks.

On return to The Oaks full nursing care was maintained as Brenda was dependent on staff for all ADLs [activities of daily living]. Brenda's condition was extremely poor, but after a period of intensive nursing care with input from the outreach physiotherapy and CPN service her condition improved dramatically. Despite this she remained too frail to return to the bungalow. The improvement was maintained until October 2000 and Brenda was able to enjoy her life at The Oaks – she enjoyed the company of her husband and the activities and the social life that were on offer.

In October she had another bout of physical illness after which she became increasingly restless and agitated, obtaining very little sleep, so various drug regimes were commenced by the GP, all of which had to be discontinued because they caused excessive drowsiness or other side effects.

continued

Brenda's mental health appeared to deteriorate and she constantly shouted out for assistance. Despite much reassurance from staff, her husband and other residents, she was unable to control this behaviour. The behaviour began to cause everyone involved much distress, especially her husband. She was sleeping very little – in fact some nights no sleep was obtained – and she continued to shout despite one-to-one nursing care being maintained.

Her gait started to become increasingly unsteady and falls started to become a problem. She sustained several minor injuries and had a couple of trips to casualty.

I spent a lot of time talking to Brenda and she was able to express that she felt low in spirits and the reason for her shouting was because she didn't feel safe and she was frightened that she would be left alone and not get any help when she needed it. Even when help was actually present she would continue to call out. I challenged her about this and she claimed that she knew she shouldn't shout but she couldn't help it even though she knew help was present and then she apologised.

I found that she was disorientated in time and place but with minimal prompting she could agree where she was. She had no difficulty remembering individual staff and their names, but her short-term memory for other things was quite poor. There was some degree of expressive dysphasia but no receptive dysphasia was apparent.

By early April Brenda's condition was still deteriorating and despite all the efforts of the GP who had tried all the various medications a direct phone call was made to the psycho-

continued

geriatrician to request an urgent visit and a recommended care plan/contract was drawn up with Brenda and Jim's agreement. Five minutes of attention every hour would be given but she would not get any attention as a result of inappropriate behaviour. I discussed this approach with the couple and they agreed to try. I reassured them both the care plan would be reviewed daily to ensure that it was still appropriate. I talked to the staff and explained that although Brenda might be quiet at the time when a visit was due they must still give Brenda attention as a way of reinforcing appropriate behaviour. Brenda's behaviour remained almost unchanged with the implementation of this care plan.

Brenda has remained resident in The Oaks until the current time (May 2003). Her mental condition is slowly deteriorating and the episodes of loud behaviour are becoming even more frequent and difficult to manage in the Oaks environment. She is prone to episodes of shouting continuously for up to 48 hours.

She continues to display appropriate behaviour when placed in situations that she enjoys, i.e. shopping at the local mall, but even this she now has difficulty controlling at times. Although Brenda enjoys the company of her husband in the home he has difficulty coping with her behaviour so is beginning to withdraw, spending more time with other residents with whom he has struck up a friendship.

Owing to the difficulties it has been reluctantly decided that a period of respite in hospital will be sought to enable Brenda to experience a change in environment, which she often responds well to, and enable other

continued

residents including her husband to have a period of respite themselves.

By continuing to find appropriate solutions we are enabling Brenda and her husband to remain together for as long as possible. At a recent case conference it was agreed that without specialist input Brenda would have had to move away from The Oaks up to three years ago. (Val Ellis, 2003)

It was recognised that education for all care workers and eventually the residents' peer group was vital to the success of the project. The following sessions were included:

1. 'What is dementia?' This session describes the aetiology and different types and progression of the illness. It gives the care assistant underpinning knowledge that will assist them in understanding the reasons for some of the symptoms and behaviour that they may encounter.
2. 'Approaches to care'. This session focused on the concept of person-centred care and the importance of obtaining a life history to maintain individualised care.

   (These two sessions were mainly aimed at care assistants who had limited experience in this field of work.)
3. 'Dementia'. This session was aimed at registered general nurses with little or no previous experience of dealing with this client group. It gave an understanding of the condition and the associated behaviour.
4. 'An introduction to dementia'. This session was aimed at ancillary staff/kitchen staff all of whom have direct contact with the residents. Its aim was to raise the overall awareness of dementia within the Hartrigg

team. This session is also aimed at carers and older people themselves in the community.

Graham Stokes visited Hartrigg Oaks on several occasions as an external speaker to provide updated and current views on providing person-centred holistic care. These sessions included 'Dementia and residents with learning difficulties' and 'Anxiety and adjustment in old age'.

Care staff, both trained and untrained, were invited to comment on the value of running a monthly staff support group. Staff felt that this was a positive step, and would identify potential issues regarding care. Val, Peter and Linda subsequently ran these jointly, as this would facilitate networking and better understanding of day-to-day staff/carer needs and related stress.

Feedback from the support group training was positive with recommendations that timing be varied to ensure that a wide cross-section of staff were able to attend. There was overwhelming feeling that the group should be confidential, with 'Chatham House Rules' applying, to allow a free and frank exchange of views, problems and anxieties.

Having run these sessions for a year, it is clear that staff are enthusiastic about improving their therapeutic role when caring for those with dementia, especially in its early stages. In addition to providing a staff support facility the sessions have proved to be an opportunity to increase their knowledge and skills, using a problem-solving format, i.e. to resolve day-to-day concerns in order to improve client care. Quite often staff are pleased to discover that the care they have been providing has been appropriate, and the feedback from Val, Peter and Linda to this effect has proved reassuring.

The original aim for the Specialist Nurse Project was becoming clearer and following a number of development meetings of the project team the following proposals were developed to ensure the work was ongoing:

1 Formulate an additional tool once cognitive loss was triggered on the original MDS RAI (Resident Assessment Instrument) form.

2 Setting up of staff support groups.

3 Teaching and education of all staff.

4 Education and updating for project worker.

5 Implementation of group work and individual support, i.e. reminiscence for clients.

6 Assistance to all grades of care staff with person-centred care/planning.

7 Intervention with individual residents when requested by the care staff.

8 Education of all residents regarding mental health issues for those interested or concerned.

9 Respite day care for bungalow residents to allow the informal carers a break.

Case study 2

Jenny was a registered nurse who was married to an army doctor who died before she came to live at Hartrigg Oaks. She has two daughters and one son.

Jenny moved to Hartrigg Oaks and took up residence alone in a bungalow.

She had some memory loss and had difficulty coping alone so the bungalow care team arranged in conjunction with her family a package of care that enabled her to live with some independence. This included care staff visiting the bungalow each morning to assist with dressing, preparing breakfast and making sure Jenny had taken her medication. They would escort Jenny to and from the

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restaurant for lunch where the carer would stay with Jenny providing company and direction if this was needed. A mid-afternoon drop-in visit was made to the bungalow to prepare an afternoon drink and the evening meal and finally each day a carer visited and would assist Jenny to prepare for bed and again ensure that all medication was taken. This package of care worked well for approximately two years.

I visited Jenny at her bungalow with a senior home care assistant and found that latterly the situation she was experiencing had become very isolated and disabling. Her only social interaction was with her carers and infrequent visits from her family – this was possibly affecting her withdrawn state and inability to converse and she also complained of a very dry mouth.

I suggested that Jenny could begin to interact with the Oaks residents to improve her quality of life, perhaps by attending activities in The Oaks like the games afternoon, or simply inviting her to the care centre to interact with the other residents, thereby reducing her loneliness and providing her with a role that could be partially fulfilled by offering simple help and company to some of the more dependent residents, showing her caring nature. Care staff would also be able to monitor Jenny's overall condition and provide adequate fluids etc.

Before this package of care was in place Jenny required hospital admission for physical health problems, therefore after consultation with the family and Jenny it was decided that she would become a permanent resident in The Oaks care centre.

continued

Initially after taking up residence Jenny seemed unsettled owing to her memory loss and her difficulty expressing herself verbally. She compensated for this by taking on her previous role as a nurse and tried to occupy herself by assisting the staff etc. but as she has become more familiar with the environment she has settled in and takes an active yet quiet part in the activities available such as the reminiscence group, physical activity and individual outings to local attractions. She has also been able to interact with acquaintances that she had previously acquired in the wider Hartrigg community. (Val Ellis, 2003)

What became clear was that specialist support was just that – support. Staff did not necessarily need to have a full-time RMN/specialist working in their unit all of the time. What they did need was ready access to specialist help as and when required.

Interviews with staff at Hartrigg Oaks revealed that they valued having someone to call on when required.

One group of staff, those working in ancillary roles, i.e. cooks, cleaners etc., particularly valued training. These staff members are often left out of training sessions related to care and yet are frequently faced with situations they feel unable to cope with. For instance, simple understanding of mental health conditions and good communication skills has enabled this group of staff to support clients more fully and sympathetically.

At the start of the project staff felt unable to manage people who displayed behaviour perceived to be out of the ordinary. Many staff members had little experience of close contact with people with dementia and had preconceptions that were based on media and other stereotypical negative portrayals. One very positive change following on from training and support groups is

that the staff almost completely turned around their attitude. Understanding about dementia and the reasons for behaviour made many staff increasingly tolerant, sympathetic and supportive of residents with dementia, and indeed upheld their right to live within the community like others.

One group of residents posed specific challenges. These were the peers of the people with dementia themselves. We were finding a limited tolerance of people with dementia from fellow residents. It was hard to determine whether this peer group were against the individual, their behaviour or their condition.

Informal focus groups were formed to ascertain why some residents were concerned. Views expressed included:

> *these people* [those with dementia] *should not be here.*

Other people, however, expressed the view that whilst they valued a service that allowed people to be cared for regardless of their condition, they did not wish to be in close proximity to people who exhibited different behaviour to theirs, i.e. integration versus segregation concerns.

Several issues emerged from these groups:

- Real lack of understanding about dementia – its cause, symptoms and prognosis.
- 'Not in my backyard' syndrome. Many people wanted a specialist service for themselves if they needed it in future but did not want to see a service for others in their home.
- Fear about dementia: some people still thought it was a contagious disease.
- Embarrassment (and a degree of revulsion) about some behaviour, especially those people who showed lack of inhibition.
- Fear of challenging and violent behaviour and a degree of helplessness in coping themselves when confronted by such behaviour.

These issues fell into two categories:

- lack of basic understanding
- fear that they may be affected by the condition themselves in the future.

It was decided to address these issues in two ways:

- by setting up a resident/carer group to consider all the issues
- by trying to reach a consensus on the best way of handling dementia in the home and by an education programme.

A different group of people posed very challenging problems. Whilst we had concentrated on the needs of people living in our homes for other people, we also had the need of adults with learning disabilities to consider. Many of these adults had been cared for by the Trust for up to 20 years and were beginning to age and consider their retirement options. We found that medical advances meant that many people were now living into late middle age and beyond and were in many cases also experiencing many of the symptoms of dementia and other mental health issues. The challenge for the Specialist Nurse Project will be to provide a service to these residents and their carers, to enable them to lead fulfilled lives and to remain in their homes wherever possible.

4 Dementia awareness group

A working group consisting of Hartrigg Oaks residents, care staff, management, JRHT specialist nurse and external advisers including a consultant psychiatrist has been formed at Hartrigg Oaks.

The purpose of the group is to study the issues surrounding the care of people with dementia within a continuing care retirement community

with particular focus on how the care can be delivered in the context of a general nursing home.

Particular areas of discussion are centred around the assessment and definitions surrounding dementia and challenging behaviour. Consideration is also being given to ways in which the well-being of residents can be increased through appropriate activities, diversional therapy etc. The use of technology is also being considered.

A broader concern is how to increase awareness of issues surrounding the care of people with dementia and the condition in general with regard to residents in the wider community at Hartrigg Oaks.

5 Education

Since undertaking the 'Mental health in old age' module at the Department of Health Sciences at the University of York Val has endeavoured to disseminate her learning about the topic and skills required associated with mental health care to her colleagues across a variety of disciplines.

She has achieved this by facilitating training sessions and support groups with a variety of care workers who come into contact with clients, e.g. trained staff who are not RMN, care assistants and general assistants including kitchen and ancillary staff. By increasing the overall level of awareness and understanding for all staff who come into contact with clients, they now have a greater understanding/knowledge base to respond positively and sympathetically to client need. In addition, this has improved staff morale and job satisfaction.

6 Conclusion/points arising

Even before the project was completed it was very clear that the benefits of specialist staff were apparent. Lessons that were learnt were:

- The need for thorough, holistic assessment of people and the use of an assessment tool that can highlight the multifaceted needs of each individual. MDS was able to indicate via the cognitive loss scale that people had varying cognitive impairment and that early intervention was beneficial to their quality of life for residents and those around them.
- Interventions had to be negotiated with all concerned and the role of the specialist nurse in helping to determine care plans was vital. Whilst specialist assistance from psycho-geriatricians and community psychiatric nurses was available through the health services, an on-the-spot specialist meant that assistance could come quickly, could be regularly monitored and was flexible to meet rapidly changing needs.
- A whole-systems approach needed to be taken with mental health issues. The study shows that everyone concerned with the individual resident should be included.
- The specialist staff also need a support mechanism and throughout this study Val received clinical supervision from Peter Cox from the University of York. This support was multifaceted and included mentoring, professional advice, guidance with continuing professional development etc.
- The specialist staff need to be part of the mainstream funding/staff complement.
- Support to residents with special health needs cannot be considered in the short term.
- People, especially those with dementia, need long-term support which can be best achieved by long-term specialist input.

It is envisaged that the work and research already undertaken for this project will continue to be investigated and developed further.

Acknowledgements

I would like to thank Linda Auer for her help and support over the course of the project. Thanks are also due to the Alzheimer's Society, Dementia North and Dr Graham Stokes for their information and resource facilities.