

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and Social Care Quality Programme

Briefing paper

Quality standard topic: Mental wellbeing of older people in residential care

Output: Prioritised quality improvement areas for development.

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1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for the mental wellbeing of older people in residential care. It provides the Committee with a basis for discussion and prioritising quality improvement areas for developing quality statements and measures, which will be drafted for public consultation.

Structure

The structure of this briefing paper includes a brief overview of the topic followed by a summary of each of the suggested quality improvement areas followed with supporting information.

Where relevant, guidance recommendations selected from the key development source below are presented to aid the Committee when considering specific aspects for which statements and measures should be considered.

Development sources

The key development sources referenced in this briefing paper are as follows:

- [Common mental health disorders](#). NICE clinical guideline 123 (2011).
- [Generalised anxiety disorder and panic disorder \(with or without agoraphobia\) in adults](#). NICE clinical guideline 113 (2011).
- [Depression in adults with a chronic physical health problem](#). NICE clinical guideline 91 (2009).
- [Depression in adults](#). NICE clinical guideline 90 (2009).
- [Mental wellbeing and older people](#) - Guidance for Occupational therapy and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care. NICE public health guidance 16 (2008).
- [Dementia](#). NICE clinical guideline 42 (2006, amended 2011).

Where relevant selected guidance recommendations from the key development sources are presented alongside each of the suggested areas for quality improvement within the main body of the report.

2 Overview

2.1 *Focus of quality standard*

This quality standard will cover the mental wellbeing of older people (65 and older) in residential care.

The primary focus of this quality standard is on promoting mental wellbeing (including life satisfaction, optimism, self-esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support).

It will also consider the identification by care home staff of suspected common mental health conditions, and referral to healthcare professionals as appropriate.

This quality standard will complement and support the NICE quality standards on:

- [Supporting people to live well with dementia quality standard \(QS30\)](#)
- [Depression in adults quality standard \(QS8\)](#)
- Anxiety quality standard (in development)

2.2 Definition

This quality standard, and the underpinning source guidance of NICE public health guidance 16¹, follows the definition of 'mental wellbeing' developed by NHS Health Scotland as part of their national programme of work on mental health improvement. This definition includes areas such as **life satisfaction, optimism, self-esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support** (NHS Health Scotland 2006).

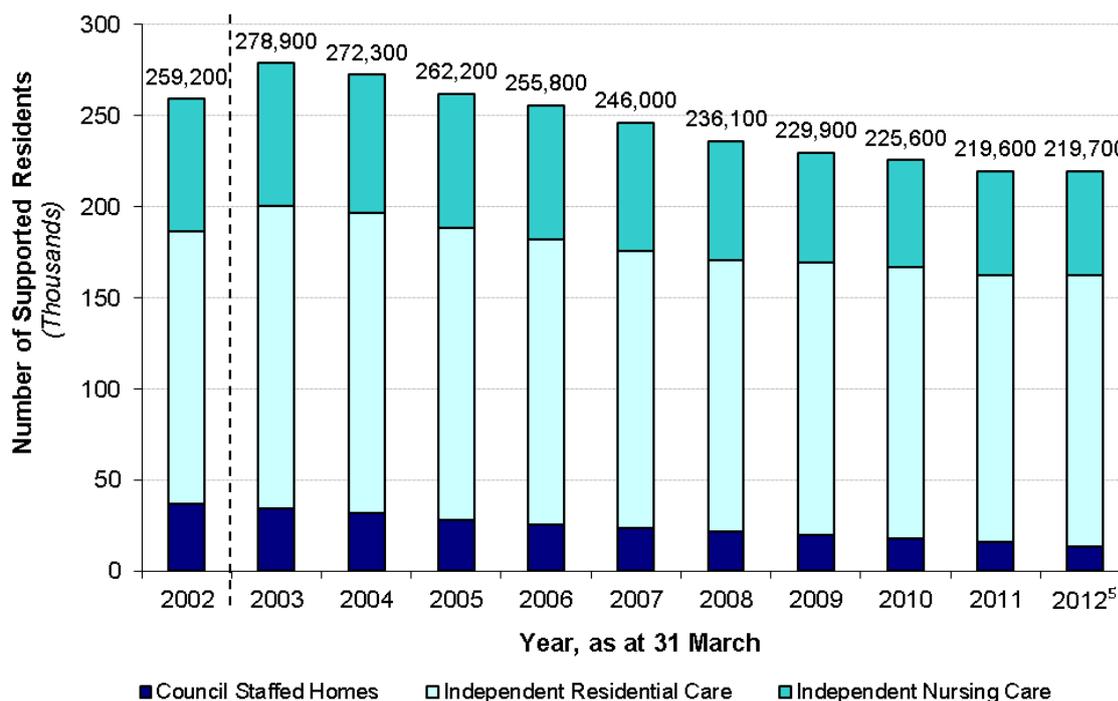
Occupational therapy aims to enable people who have physical, mental and/or social needs, either from birth or as a result of accident, illness or ageing, to achieve as much as they can to get the most out of life (College of Occupational Therapists 2008).

2.3 Incidence and prevalence

At March 2012, there were 219,700 supported residents in registered accommodation, this represents people receiving care in residential and nursing accommodation funded by Councils with Adult Social Services Responsibilities (CASSRs) in England (The Health and Social Care Information Centre, 2012). It is estimated that 77% of this group were aged 65 and over and 43% were aged 85 and over.

Figure 1 Number of Supported Residents by type of accommodation 2002 to 2012 (from Community Care Statistics, Social Services Activity - England, 2011-12)

¹ This guidance is for all those involved in promoting older people's mental wellbeing. It focuses on practical support for everyday activities, based on occupational therapy principles and methods. This includes working with older people and their carers to agree what kind of support they need.



Source: Health and Social Care Information Centre

Common mental health disorders, such as depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder, may affect up to 15% of the population at any one time. There is considerable variation in the severity of common mental health disorders, but all can be associated with significant long-term disability.

Though many older people lead happy, well-balanced and independent lives, a proportion will have low levels of life satisfaction and wellbeing.

There are a large number of older people living with symptoms of dementia, depression and anxiety in residential care homes:

- Forty per cent of older people attending GP surgeries, and 60% of those living in residential institutions are reported to have 'poor mental health'².
- The prevalence of depression within care homes has been estimated at 40%, anxiety from 6% to 30%, delirium as being 'very common' and dementia from 50% to 80%³.

² UK Inquiry into Mental Health and Well-Being in Later Life (2006) Promoting mental health and wellbeing in later life. London: Age Concern and Mental Health Foundation.

³ UK Inquiry into Mental Health and Well-Being in Later Life (2006) Promoting mental health and wellbeing in later life. London: Age Concern and Mental Health Foundation.

2.4 Management

Interventions and activities that promote mental wellbeing in older people can be defined as: 'any activity or action that strengthens or protects mental health and wellbeing'⁴.

The vast majority (up to 90%) of depressive and anxiety disorders that are diagnosed are treated in primary care. However, many individuals do not seek treatment, and both anxiety and depression often go undiagnosed. Although under-recognition is generally more common in mild rather than severe cases, mild disorders are still a source of concern.

Recognition of anxiety disorders by GPs is particularly poor, and only a small minority of people who experience anxiety disorders ever receive treatment.

In part this may stem from GPs' difficulties in recognising the disorder, but it may also be caused by patients' worries about stigma, and avoidance on the part of individual patients.

The most common method of treatment for common mental health disorders in primary care is psychotropic medication. This is due to the limited availability of psychological interventions, despite the fact that these treatments are generally preferred by patients.

Similarly for dementia, when identified, there are effective interventions for symptom control, promoting and maintaining the independence of people with dementia, and providing support for carers.

However, the recognition of common mental health disorders and dementia, and access to appropriate treatment may be more problematic in older people in residential care.

2.5 National Outcome Frameworks

The table below shows the indicators from the outcomes frameworks that the quality standard could contribute to:

- [The NHS Outcomes Framework 2013/14](#)
- [The Adult Social Care Outcomes Framework 2013/14](#)

NHS Outcomes Framework 2013/14	
Domain 1: Preventing people from dying prematurely.	Overarching indicators 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults 1b Life expectancy at 75 i Males ii Females <i>Improvement areas</i>

⁴ UK Inquiry into Mental Health and Well-Being in Later Life (2006) Promoting mental health and wellbeing in later life. London: Age Concern and Mental Health Foundation.

	<p>Reducing premature death in people with serious mental illness</p> <p>1.5 Excess under75 mortality rate in adults with serious mental illness⁵</p>
<p>Domain 2: Enhancing quality of life for people with long-term conditions.</p>	<p>Overarching indicator</p> <p>Health-related quality of life for people with long-term conditions⁶</p> <p><i>Improvement areas</i></p> <p>Ensuring people feel supported to manage their condition</p> <p>2.1 Proportion of people feeling supported to manage their condition⁶</p> <p>Improving functional ability in people with long-term conditions</p> <p>2.2 Employment of people with long-term conditions⁵⁶</p> <p>Reducing time spent in hospital by people with long-term conditions</p> <p>Enhancing quality of life for carers</p> <p>2.4 Health-related quality of life for carers⁶</p> <p>Enhancing quality of life for people with mental illness</p> <p>Enhancing quality of life for people with dementia</p> <p>2.6 i Estimated diagnosis rate for people with dementia⁵ ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life⁷</p>
<p>Domain 4: Ensuring that people have a positive experience of care.</p>	<p><i>Improvement areas</i></p> <p>Improving access to primary care services</p> <p>4.4 Access to i GP services</p> <p>Improving experience of healthcare for people with mental illness</p> <p>4.7 Patient experience of community mental health services</p> <p>Improving people's experience of integrated care</p> <p>4.9 An indicator is under development⁷</p>
<p>Adult Social Care Outcomes Framework 2013/14</p>	
<p>Domain 1: Enhancing quality of life for people with care and support needs</p>	<p>Overarching measure</p> <p>1A. Social care-related quality of life⁸</p> <p><i>Outcome measures</i></p> <p>People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs.</p> <p>1B. Proportion of people who use services who have control over their daily life</p> <p>To be revised from 2014/15:1C. Proportion of people using social care who receive self-directed support, and those receiving direct payments</p> <p>Carers can balance their caring roles and maintain their desired quality of life.</p> <p>1D. Carer-reported quality of life⁸</p> <p>People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.</p> <p>New measure for 2013/14:1I. Proportion of people who use services and their carers, who reported that they had as much social contact as they would like.⁹</p>

5 Indicator shared with Public Health Outcomes Framework (PHOF)

6 Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)

7 Indicator shared with Adult Social Care Outcomes Framework

8 Measure complementary with another framework

<p>Domain 2: Delaying and reducing the need for care and support.</p>	<p>Overarching measures 2A. Permanent admissions to residential and nursing care homes per 1,000 population <i>Outcome measures</i> Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs. Earlier diagnosis, intervention and re-ablement means that people and their carers are less dependent on intensive services. 2B. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services New placeholder 2F: Dementia –a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life.</p>
<p>Domain 3: Ensuring that people have a positive experience of care and support.</p>	<p>Overarching measure People who use social care and their carers are satisfied with their experience of care and support services. 3A. Overall satisfaction of people who use services with their care and support 3B. Overall satisfaction of carers with social services New placeholder 3E: Improving people’s experience of integrated care⁹ <i>Outcome measures</i> Carers feel that they are respected as equal partners throughout the care process. 3C. The proportion of carers who report that they have been included or consulted in discussions about the person they care for People know what choices are available to them locally, what they are entitled to, and who to contact when they need help. 3D. The proportion of people who use services and carers who find it easy to find information about support People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual. This information can be taken from the Adult Social Care Survey and used for analysis at the local level.</p>
<p>Domain 4: Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.</p>	<p>Overarching measure 4A. The proportion of people who use services who feel safe <i>Outcome measures</i> Everyone enjoys physical safety and feels secure. People are free from physical and emotional abuse, harassment, neglect and self-harm. People are protected as far as possible from avoidable harm, disease and injuries. People are supported to plan ahead and have the freedom to manage risks the way that they wish. 4B. The proportion of people who use services who say that those services have made them feel safe and secure New placeholder 4C: Proportion of completed safeguarding referrals where people report they feel safe</p>

3 Summary of suggestions

3.1 Responses

In total 12 stakeholders responded to the 2-week engagement exercise (11/03/2013 to 25/03/2013). Suggestions were also provided by specialist committee members.

Table 1 Summary of suggested quality improvement areas

Stakeholders were asked to suggest up to 5 areas for quality improvement. These have been merged and summarised in the table below for further consideration by the Committee (incorporating stakeholder and specialist committee member suggestions). The full detail of the suggestions is provided in appendix 4 for information.

Suggested area for improvement	Stakeholder (see table 2 for abbreviations)
<u>Participation in meaningful activity</u> a) Opportunities to engage in daily routines and activities b) Opportunities for social participation and engagement	AS, COT, NICE SCF, PUK and LBS RCGP, SCM, UoE
<u>Access to services</u> a) Access to healthcare b) Access to occupational therapy c) Input from specialist older people's mental health services	AS, BABCP, BGS, COT, PUK and LBS, SCM, UKCP
<u>Impact of physical conditions</u> a) Reduction of the impact of sensory impairment b) Early identification of conditions relating to sight c) Responsiveness of residential care home staff to the specific needs of people with physical conditions	MS, NICE SCF, PUK and LBS, RCGP, RCOphth, SCM
<u>Individualised care</u>	NICE SCF, RCGP, SCM
<u>Personal identity</u> a) Opportunities to maintain personal identity	RCGP
<u>Involvement of families</u>	BABCP, SCM
<u>Environmental factors</u>	PUK and LBS, UoE
<u>Organisational factors</u> a) Training b) Identification of a lead for quality improvement	AS, BABCP, CQC, PUK and LBS, UKCP

Table 2 Stakeholder details (abbreviations)

The details of stakeholder organisations who submitted suggestions are provided in the table below.

Abbreviation	Full name
AS	Alzheimer's Society
BABCP	British Association for Behavioural & Cognitive Psychotherapy
BGS	British Geriatrics Society
COT	College of Occupational Therapists
CQC	Care Quality Commission
MS	Macular Society
NICE SCF	NICE Social Care Fellow
PUK and LBS	Parkinson's UK and Lewy Body Society
RCGP	Royal College of General Practitioners
RCOphth	Royal College of Ophthalmologists
SCM	Specialist Committee Member
UKCP	UK Council for Psychotherapy
UoE	University of Edinburgh

4 Suggested improvement area: participation in meaningful activity

4.1 Summary of suggestions

Stakeholders highlighted the importance of 'opportunities to engage in daily activities' for older people in residential care. This includes mental, physical and social activities which may take a number of forms.

Stakeholders placed particular emphasis on ensuring flexibility and variety of daily activities, and social participation and engagement.

Specialist committee members also emphasised the importance of engaging in meaningful occupation and activity for older people in residential care. They stated that opportunities for activity should be regular, appropriate and should include naturally occurring opportunities for occupation.

Suggested quality improvement area	NICE guidance
a) Opportunities to engage in daily routines and activities	<ul style="list-style-type: none">• NICE public health guidance 16, recommendation 1 (Occupational therapy interventions)• NICE clinical guideline 42, recommendation 1.5.1.1 (Promoting and maintaining independence of people with dementia)
b) Opportunities for social participation and engagement	<ul style="list-style-type: none">• Not directly covered in relevant NICE guidelines and no recommendations are presented

4.2 Selected recommendations from development source

Recommendations from the development source relating to the suggested improvement areas have been provisionally selected and are presented below to inform QSAC discussion.

a) Opportunities to engage in physical activity

Mental wellbeing and older people. NICE public health guidance 16 (2008).

NICE PH16 Recommendation 1 Occupational therapy interventions

Who is the target population?

- Older people and their carers.

Who should take action?

- Occupational therapists or other professionals who provide support and care services for older people in community or residential settings and who have been trained to apply the principles and methods of occupational therapy.

What action should they take?

- Offer regular group and/or individual sessions to encourage older people to identify, construct, rehearse and carry out daily routines and activities that help to maintain or improve their health and wellbeing.

Sessions should:

- involve older people as experts and partners in maintaining or improving their quality of life
- pay particular attention to communication, physical access, length of session and informality to encourage the exchange of ideas and foster peer support
- take place in a setting and style that best meet the needs of the older person or group
- provide practical solutions to problem areas.
- Increase older people's knowledge and awareness of where to get reliable information and advice on a broad range of topics, by providing information directly, inviting local advisers to give informal talks, or arranging trips and social activities. Topics covered should include:
 - meeting or maintaining healthcare needs (for example, eye, hearing and foot care)
 - nutrition (for example, healthy eating on a budget)
 - personal care (for example, shopping, laundry, keeping warm)
 - staying active and increasing daily mobility
 - getting information on accessing services and benefits
 - home and community safety
 - using local transport schemes.
- Invite regular feedback from participants and use it to inform the content of the sessions and to gauge levels of motivation.

Dementia. NICE clinical guideline 42 (2006, amended 2011).

NICE CG42 Recommendation 1.5.1.1 Promoting and maintaining independence of people with dementia

Health and social care staff should aim to promote and maintain the independence, including mobility, of people with dementia. Care plans should address activities of daily living (ADLs) that maximise independent activity, enhance function, adapt and develop skills, and minimise the need for support. When writing care plans, the varying needs of people with different types of dementia should be addressed. Care plans should always include:

- consistent and stable staffing
- retaining a familiar environment
- minimising relocations
- flexibility to accommodate fluctuating abilities
- assessment and care-planning advice regarding ADLs, and ADL skill training from an occupational therapist
- assessment and care-planning advice about independent toileting skills; if incontinence occurs all possible causes should be assessed and relevant treatments tried before concluding that it is permanent
- environmental modifications to aid independent functioning, including assistive technology, with advice from an occupational therapist and/or clinical psychologist
- physical exercise, with assessment and advice from a physiotherapist when needed
- support for people to go at their own pace and participate in activities they enjoy.

4.3 Current UK practice

Stakeholders highlighted that care home residents are more likely to occupy their time in the main sitting room passively, rather than in interactive occupation and social engagement. It was noted that nursing home residents with dementia spent approximately 70% of their time in the main sitting room areas in states of occupational disengagement.¹⁰

Stakeholders highlighted that research has shown that only 44% of families surveyed felt that opportunities for activities in the care home were 'good'¹¹.

Although not directly related to the NICE quality standards context, a report by the Mental Welfare Commission for Scotland (2012) found that overall there is good availability of activities in care homes although they are not always tailored to the needs of individuals and are sometimes not recorded well¹².

Stakeholders also drew attention to NICE public health guideline 16: Mental Wellbeing and older people.

¹⁰ Morgan-Brown M, Ormerod M, Newton R, Manley D. An exploration of occupation in nursing home residents with dementia. *The British Journal of Occupational Therapy* 2011; volume 74; 5; 217-225.

¹¹ The Alzheimer's Society (2013). [Low Expectations Attitudes on choice, care and community for people with dementia in care homes.](#)

¹² Mental Welfare Commission for Scotland (2012) [Summary of outcomes from focussed visits 2010-11.](#)

5 Suggested improvement area: access to services

5.1 Summary of suggestions

Stakeholders highlighted the need for older people in residential care to have access to appropriate healthcare services. This was both for general healthcare, including physical health, but also access to services for early and competent assessment of mental health conditions.

Stakeholders also highlighted the importance of access to occupational therapy and input from specialist older people’s mental health services. Comments stated that access to in-reach specialist older people’s mental health teams is recommended in the National Dementia Strategy for England. They also highlighted that the NICE Guideline on dementia (CG42) makes it clear that care homes should receive good support from external services.

Specialist committee members also highlighted the need for access to appropriate services. More specifically, they raised the issue of early identification of mental health conditions and management of medication. Early planning for end of life care was also suggested. However, it is noted that this is considered likely to be addressed by the quality standard for end of life care for adults (QS13).

Additional areas suggested were access to therapies and specialist support for diagnosed dementia and mental health disorders; however, these are outside the scope of this quality standard and are considered more relevant for the topic-specific quality standards (published, in development, or in the core library).

Suggested quality improvement area	NICE guidance
a) Access to healthcare	<ul style="list-style-type: none"> • NICE clinical guideline 123 recommendations 1.1.1.5, 1.1.1.7 (Improving access to services) • NICE clinical guideline 123 recommendations 1.3.1.1, 1.3.1.2, 1.3.1.3 (Identification) • NICE clinical guideline 123 recommendations 1.3.2.1, 1.3.2.4, 1.3.2.5 (Assessment) • NICE clinical guideline 113 recommendations 1.2.2, 1.2.3, 1.2.4 (Identification) • NICE clinical guideline 91 recommendation 1.3.1 (Case identification and recognition) • NICE clinical guideline 90 recommendations 1.3.1.1, 1.3.1.2, 1.3.1.3, 1.3.1.4, 1.3.1.5 (Case identification and recognition)

	<ul style="list-style-type: none"> NICE clinical guideline 42 recommendations 1.3.3.1, 1.3.3.2 (Early identification of dementia)
b) Access to occupational therapy	<ul style="list-style-type: none"> NICE public health guidance 16 recommendation 1 (Occupational therapy interventions) and recommendation 4 (Training) NICE clinical guideline 42 recommendation 1.5.1.1 (Promoting and maintaining independence of people with dementia)
c) Input from specialist older people's mental health services	<ul style="list-style-type: none"> Not directly covered in relevant NICE guidelines and no recommendations are presented.

5.2 ***Selected recommendations from development source***

Recommendations from the development source relating to the suggested improvement areas have been provisionally selected and are presented below in inform QSAC discussion.

Input from specialist mental health services is not directly covered in the relevant NICE clinical guidelines and no recommendations are presented relating to the suggested area for quality improvement area.

a) Access to healthcare

Common mental health disorders. NICE clinical guideline 123 (2011).

Note: there are a range of structural and organisational recommendations in this guideline. Only the most relevant have been presented below.

NICE CG123 Recommendation 1.1.1.5 Improving access to services

Primary and secondary care clinicians, managers and commissioners should collaborate to develop local care pathways that promote access to services for people with common mental health disorders from a range of socially excluded groups including:

- black and minority ethnic groups
- older people
- those in prison or in contact with the criminal justice system
- ex-service personnel.

NICE CG123 Recommendation 1.1.1.7 Improving access to services

Support access to services and increase the uptake of interventions by providing services for people with common mental health disorders in a variety of settings. Use an assessment of local needs as a basis for the structure and distribution of services, which should typically include delivery of:

- assessment and interventions outside normal working hours
- interventions in the person's home or other residential settings
- specialist assessment and interventions in non-traditional community-based settings (for example, community centres and social centres) and where appropriate, in conjunction with staff from those settings
- both generalist and specialist assessment and intervention services in primary care settings.

NICE CG123 Recommendation 1.3.1.1 Identification

Be alert to possible depression (particularly in people with a past history of depression, possible somatic symptoms of depression or a chronic physical health problem with associated functional impairment) and consider asking people who may have depression two questions, specifically:

- During the last month, have you often been bothered by feeling down, depressed or hopeless?
 - During the last month, have you often been bothered by having little interest or pleasure in doing things?
- If a person answers 'yes' to either of the above questions consider depression and follow the recommendations for assessment.

NICE CG123 Recommendation 1.3.1.2 Identification

Be alert to possible anxiety disorders (particularly in people with a past history of an anxiety disorder, possible somatic symptoms of an anxiety disorder or in those who have experienced a recent traumatic event). Consider asking the person about their feelings of anxiety and their ability to stop or control worry, using the 2-item Generalized Anxiety Disorder scale (GAD-2).

- If the person scores three or more on the GAD-2 scale, consider an anxiety disorder and follow the recommendations for assessment.
- If the person scores less than three on the GAD-2 scale, but you are still concerned they may have an anxiety disorder, ask the following: 'Do you find yourself avoiding places or activities and does this cause you problems?'. If the person answers 'yes' to this question consider an anxiety disorder and follow the recommendations for assessment.

NICE CG123 Recommendation 1.3.1.3 Identification

For people with significant language or communication difficulties, for example people with sensory impairments or a learning disability, consider using the Distress Thermometer and/or asking a family member or carer about the person's symptoms to identify a possible common mental health disorder. If a significant level of distress is identified, offer further assessment or seek the advice of a specialist.

NICE CG123 Recommendation 1.3.2.1 Assessment

If the identification questions indicate a possible common mental health disorder, but the practitioner is not competent to perform a mental health assessment, refer the person to an appropriate healthcare professional. If this professional is not the person's GP, inform the GP of the referral.

NICE CG123 Recommendation 1.3.2.4 Assessment

All staff carrying out the assessment of suspected common mental health disorders should be competent to perform an assessment of the presenting problem in line with the service setting in which they work, and be able to:

- determine the nature, duration and severity of the presenting disorder
- take into account not only symptom severity but also the associated functional impairment
- identify appropriate treatment and referral options in line with relevant NICE guidance.

NICE CG123 Recommendation 1.3.2.5 Assessment

All staff carrying out the assessment of common mental health disorders should be competent in:

- relevant verbal and non-verbal communication skills, including the ability to elicit problems, the perception of the problem(s) and their impact, tailoring information, supporting participation in decision-making and discussing treatment options
- the use of formal assessment measures and routine outcome measures in a variety of settings and environments.

Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. NICE clinical guideline 113 (2011).

NICE CG113 Recommendation 1.2.2 Identification

Identify and communicate the diagnosis of GAD as early as possible to help people understand the disorder and start effective treatment promptly. **[new 2011]**

NICE CG113 Recommendation 1.2.3 Identification

Consider the diagnosis of GAD in people presenting with anxiety or significant worry, and in people who attend primary care frequently who:

- have a chronic physical health problem **or**
- do not have a physical health problem but are seeking reassurance about somatic symptoms (particularly older people and people from minority ethnic groups) **or**

- are repeatedly worrying about a wide range of different issues. **[new 2011]**

NICE CG113 Recommendation 1.2.4 Identification

When a person with known or suspected GAD attends primary care seeking reassurance about a chronic physical health problem or somatic symptoms and/or repeated worrying, consider with the person whether some of their symptoms may be due to GAD. **[new 2011]**

Depression in adults with a chronic physical health problem. NICE clinical guideline 91 (2009).

NICE CG91 Recommendation 1.3.1 Case identification and recognition

Be alert to possible depression (particularly in patients with a past history of depression or a chronic physical health problem with associated functional impairment) and consider asking patients who may have depression two questions, specifically:

- During the last month, have you often been bothered by feeling down, depressed or hopeless?
- During the last month, have you often been bothered by having little interest or pleasure in doing things?

If a patient with a chronic physical health problem answers 'yes' to either of the depression identification questions but the practitioner is not competent to perform a mental health assessment, they should refer the patient to an appropriate professional. If this professional is not the patient's GP, inform the GP of the referral.

If a patient with a chronic physical health problem answers 'yes' to either of the depression identification questions, a practitioner who is competent to perform a mental health assessment should:

- ask three further questions to improve the accuracy of the assessment of depression, specifically:
 - during the last month, have you often been bothered by feelings of worthlessness?
 - during the last month, have you often been bothered by poor concentration?
 - during the last month, have you often been bothered by thoughts of death?
- review the patient's mental state and associated functional, interpersonal and social difficulties
- consider the role of both the chronic physical health problem and any prescribed medication in the development or maintenance of the depression

- ascertain that the optimal treatment for the physical health problem is being provided and adhered to, seeking specialist advice if necessary.

When assessing a patient with suspected depression, consider using a validated measure (for example, for symptoms, functions and/or disability) to inform and evaluate treatment.

For patients with significant language or communication difficulties, for example patients with sensory impairments or a learning disability, consider using the Distress Thermometer and/or asking a family member or carer about the patient's symptoms to identify possible depression. If a significant level of distress is identified, investigate further.

Depression in adults. NICE clinical guideline 90 (2009).

NICE CG90 Recommendation 1.3.1.1 Case identification and recognition

Be alert to possible depression (particularly in people with a past history of depression or a chronic physical health problem with associated functional impairment) and consider asking people who may have depression two questions, specifically:

- During the last month, have you often been bothered by feeling down, depressed or hopeless?
- During the last month, have you often been bothered by having little interest or pleasure in doing things?

NICE CG90 Recommendation 1.3.1.2 Case identification and recognition

If a person answers 'yes' to either of the depression identification questions but the practitioner is not competent to perform a mental health assessment, they should refer the person to an appropriate professional. If this professional is not the person's GP, inform the GP of the referral.

NICE CG90 Recommendation 1.3.1.3 Case identification and recognition

If a person answers 'yes' to either of the depression identification questions, a practitioner who is competent to perform a mental health assessment should review the person's mental state and associated functional, interpersonal and social difficulties.

NICE CG90 Recommendation 1.3.1.4 Case identification and recognition

When assessing a person with suspected depression, consider using a validated measure (for example, for symptoms, functions and/or disability) to inform and evaluate treatment.

NICE CG90 Recommendation 1.3.1.5 Case identification and recognition

For people with significant language or communication difficulties, for example people with sensory impairments or a learning disability, consider using the Distress Thermometer and/or asking a family member or carer about the person's symptoms to identify possible depression. If a significant level of distress is identified, investigate further.

Dementia. NICE clinical guideline 42 (2006, amended 2011).

NICE CG42 Recommendation 1.3.3.1 Early identification of dementia

Primary healthcare staff should consider referring people who show signs of mild cognitive impairment (MCI) for assessment by memory assessment services to aid early identification of dementia, because more than 50% of people with MCI later develop dementia.

NICE CG42 Recommendation 1.3.3.2 Early identification of dementia

Those undertaking health checks as part of health facilitation for people with learning disabilities should be aware of the increased risk of dementia in this group. Those undertaking health checks for other high-risk groups, for example those who have had a stroke and those with neurological conditions such as Parkinson's disease, should also be aware of the possibility of dementia.

b) Access to occupational therapy

Mental wellbeing and older people. NICE public health guidance 16 (2008).

NICE PH16 Recommendation 1 Occupational therapy interventions

Who is the target population?

- Older people and their carers.

Who should take action?

- Occupational therapists or other professionals who provide support and care services for older people in community or residential settings and who have been trained to apply the principles and methods of occupational therapy.

What action should they take?

- Offer regular group and/or individual sessions to encourage older people to identify, construct, rehearse and carry out daily routines and activities that help to maintain or improve their health and wellbeing. Sessions should:
 - involve older people as experts and partners in maintaining or improving their quality of life
 - pay particular attention to communication, physical access, length of session and informality to encourage the exchange of ideas and foster peer support

- take place in a setting and style that best meet the needs of the older person or group
- provide practical solutions to problem areas.
- Increase older people's knowledge and awareness of where to get reliable information and advice on a broad range of topics, by providing information directly, inviting local advisers to give informal talks, or arranging trips and social activities. Topics covered should include:
 - meeting or maintaining healthcare needs (for example, eye, hearing and foot care)
 - nutrition (for example, healthy eating on a budget)
 - personal care (for example, shopping, laundry, keeping warm)
 - staying active and increasing daily mobility
 - getting information on accessing services and benefits
 - home and community safety
 - using local transport schemes.
- Invite regular feedback from participants and use it to inform the content of the sessions and to gauge levels of motivation.

NICE PH16 Recommendation 4 Training

Who is the target population?

- Health and social care professionals, domiciliary care staff, residential care home managers and staff, and support workers, including the voluntary sector.

Who should take action?

- Professional bodies, skills councils and other organisations responsible for developing training programmes and setting competencies, standards and continuing professional development schemes.
- NHS and local authority senior managers, human resources and training providers and employers of residential and domiciliary care staff in the private and voluntary sector.

What action should they take?

- Involve occupational therapists in the design and development of locally relevant training schemes for those working with older people. Training schemes should include:
 - essential knowledge of (and application of) the principles and methods of occupational therapy and health and wellbeing promotion
 - effective communication skills to engage with older people and their carers (including group facilitation skills or a person-centred approach)

- information on how to monitor and make the best use of service feedback to evaluate or redesign services to meet the needs of older people.
- Ensure practitioners have the skills to:
 - communicate effectively with older people to encourage an exchange of ideas and foster peer support
 - encourage older people to identify, construct, rehearse and carry out daily routines and promote activities that help to maintain or improve health and wellbeing
 - improve, maintain and support older people's ability to carry out daily routines and promote independence
 - collect and use regular feedback from participants.

Dementia. NICE clinical guideline 42 (2006, amended 2011).

NICE CG42 Recommendation 1.5.1.1 Promoting and maintaining independence of people with dementia

Health and social care staff should aim to promote and maintain the independence, including mobility, of people with dementia. Care plans should address activities of daily living (ADLs) that maximise independent activity, enhance function, adapt and develop skills, and minimise the need for support. When writing care plans, the varying needs of people with different types of dementia should be addressed. Care plans should always include:

- consistent and stable staffing
- retaining a familiar environment
- minimising relocations
- flexibility to accommodate fluctuating abilities
- assessment and care-planning advice regarding ADLs, and ADL skill training from an occupational therapist
- assessment and care-planning advice about independent toileting skills; if incontinence occurs all possible causes should be assessed and relevant treatments tried before concluding that it is permanent
- environmental modifications to aid independent functioning, including assistive technology, with advice from an occupational therapist and/or clinical psychologist
- physical exercise, with assessment and advice from a physiotherapist when needed
- support for people to go at their own pace and participate in activities they enjoy.

5.3 *Current UK practice*

a) Access to healthcare

Overall, there was concern that older people in residential care were not getting access to appropriate NHS primary and secondary healthcare services through a coordinated model of multidisciplinary care.

This was supported by a report from the British Geriatrics Society (BGS) on the quality of healthcare support for older people in care homes¹³. For example, the report cited a survey conducted in 2010 by the multi-professional Older People's Specialists' Forum (OPSF), hosted by the BGS. This survey asked care homes across the UK about their experiences of accessing healthcare services for their residents. It found that:

- 68% of care home residents do not get a regular planned medical review by their GP
- 44% were not getting a regular planned review of their medication.
- 41% could not access specialist dementia services such as memory clinics and community mental health teams.

Reasons for why access to healthcare support is variable and patchy included:

- the lack of clear, central policy guidance
- confusion around obligations of NHS healthcare services to provide medical support to care homes
- commissioning arrangements between health and social care
- possible ageism in the NHS
- ambivalence about working with the independent sector (pp20-21).

In 2012, a BGS report¹⁴ analysing data collected by the Care Quality Commission about PCT support for the healthcare of older people living within nursing and residential care homes found that:

- There is no consensus across PCTs as commissioners about what services older people in care homes need, how care should be provided and what services can do. This follows a decade of research and

¹³ British Geriatrics Society (2011) [Quest for Quality: British Geriatrics Society Joint Working Party Inquiry into the Quality of Healthcare Support for Older People in Care Homes: A Call for Leadership, Partnership and Quality Improvement.](#)

¹⁴ British Geriatrics Society (2012) [Failing the Frail: A Chaotic Approach to Commissioning Healthcare Services for Care Homes.](#)

professional debate that has repeatedly highlighted the healthcare needs of care home residents.

- PCT interest in their services for care homes is limited. Many PCTs had difficulties in answering CQC's questions, just 51% had enhanced service agreements with GPs for work in care homes and only 12% of specialist community services involved a care home specific provider.
- CQC's data does shows that with 52 different combinations across 152 PCTs there are significant variations in the specialist services available to older people and only in 43% of PCTs are older people likely to have access to all the services they need.
- PCTs largely ignore the differences between and nursing and residential care homes and with people living in the community as for most services the same provider covered both sectors and where there were different providers they worked to the same response standard. CQC's data however is about commissioning intentions rather than the service received.
- Response standards vary greatly between services and areas and many of the longer standards seem inappropriate given the limited life expectancy of care home residents. Further nearly half of services for which there was data did not meet their response standards.
- Only 60% of PCTs provided a geriatrician service to all older people in contrast to 86-97% for the other exemplar services.
- These conclusions can be applied to older people living in the community.

Similarly, in 2013, the Alzheimer's Society report¹⁵ on the attitudes on choice, care and community for people with dementia in care homes concluded that:

- Health services play a crucial role in ensuring that people with dementia can have a good quality of life in care homes, but challenges persist in access to and support from health services for this group. DEMFAM (a survey of family members of people with dementia) found that 56% of respondents said support from GPs was good, but views on other health services were less positive.
- Views on support from dentists were mixed, with only 23% of respondents saying access and support was good.

¹⁵ The Alzheimer's Society (2013). [Low Expectations Attitudes on choice, care and community for people with dementia in care homes.](#)

- DEMFAM found that only 26% of respondents said the care home was good on opportunities for trips out of the home, and 31% said they were poor.
- Only 28% of DEMFAM respondents said the home was good with regard to volunteers coming into the home, with 22% saying it was poor.
- People with dementia in care homes must have the same access to health services and relationships in the community as all others, regardless of their disability.
- The care home sector can play a vital role supporting the development of dementia-friendly and supportive communities, and should fully engage locally and nationally with this work.

It should be noted that, whilst the reports above include access to care which could include support to promote and intervene early around mental well-being, they are not specific to mental wellbeing alone.

However, the second report of the UK Inquiry into Mental Health and Well-Being in Later Life¹⁶ cited evidence that up to 30% of residents in care homes have anxiety 'which is often overlooked' and '[o]nly half of older people in care homes who are diagnosed with depression receive any kind of treatment'.

The report noted that many mental health problems are not detected, diagnosed or treated in care homes. Barriers are similar to those recognised in primary care, and include a lack of confidence of GPs to diagnose and treat dementia, a lack of recognition of alcohol and drug problems, and a higher risk of overlooking mental health problems in older people with sensory impairments, older men and older people with lower levels of educational attainment. Psychological therapies were 'rarely offered', leaving people with 'no choice but to take anti-depressants'. This lack of access was also noted for other types of therapy, such as exercise or art therapy.

Furthermore, in care homes there are the added barriers of low expectations and complex health problems because of the high levels of physical illness and frailty in the resident population.

Care home staff are 'often under-trained, overwhelmed and generally not well supported to identify and respond to older people's mental health needs'. Also, clinical leadership within care homes is needed but often lacking (a survey of care homes found that 20% had no regular GP visits), and access to specialist services

¹⁶ UK Inquiry into Mental Health and Well-Being in Later Life (2007) Improving services and support for older people with mental health problems: The second report from the UK Inquiry into Mental Health and Well-Being in Later Life. London: Age Concern and Mental Health Foundation.

such as psychological therapies and mental health advocacy is often not available in care homes¹⁷.

b) Access to occupational therapy

Access to occupational therapy, as recommended in the NICE public health guidance 16 was considered important, and the BGS report¹⁸ cited a survey from 2001 that found 'only 3.3% of residents received occupational therapy'.

c) Input from specialist older people's mental health services

The issue of access to specialist mental health teams was raised, and this appeared to be focussed more for people with a diagnosis of a mental health condition. No specific information on how input from specialist mental health teams impacted on the promotion and maintenance of mental well-being was provided.

¹⁷ A UK Inquiry into Mental Health and Well-Being in Later Life (2007) Improving services and support for older people with mental health problems: The second report from the UK Inquiry into Mental Health and Well-Being in Later Life. London: Age Concern and Mental Health Foundation.

¹⁸ British Geriatrics Society (2011) [Quest for Quality: British Geriatrics Society Joint Working Party Inquiry into the Quality of Healthcare Support for Older People in Care Homes: A Call for Leadership, Partnership and Quality Improvement.](#)

6 Suggested improvement area: impact of physical conditions

6.1 Summary of suggestions

Stakeholders raised serious concerns relating to the identification and management of sensory impairment in older people in residential care homes. There was a particular focus on sight loss and the psychological impact it has if not treated and managed. It was suggested that early identification of conditions affecting sight could reduce the impact of eye disease. This was highlighted as relevant because stakeholders felt that visual impairment can have a negative impact on mental wellbeing and potentially exacerbate conditions such as dementia.

Specialist committee members also raised the issue of sensory impairment suggesting that addressing and making reasonable adjustments to accommodate sensory impairment is of high importance. They reported evidence of under recognition of sensory impairment and failure to promote use of supportive aids and technology in care homes.

Stakeholders highlighted the issue of the ability of care home staff to respond appropriately to physical conditions affecting older people. A range of conditions were mentioned including incontinence and Parkinson's disease.

The following specific areas for quality improvement and potential development by the QSAC were highlighted, shown in table below alongside recommendations that have been provisionally selected from the development source to support potential statement development.

Suggested quality improvement area	NICE guidance
a) Reduction of the impact of sensory impairment	<ul style="list-style-type: none"> • NICE public health guidance 16, recommendation 1 (Occupational therapy interventions) • NICE clinical guideline 91, recommendation 1.3.1.5 (Case identification and recognition) • NICE clinical guideline 42, recommendation 1.1.1.4 (Diversity, equality and language)
b) Early identification of conditions relating to sight	<ul style="list-style-type: none"> • Not directly covered in relevant NICE guidelines and no recommendations are presented
c) Responsiveness of residential care home staff to the specific needs of people with physical conditions	<ul style="list-style-type: none"> • NICE clinical guideline 42 recommendations 1.1.1.4 (Diversity, equality and language), 1.1.7.2 (Management and coordination of care)

6.2 Selected recommendations from development source

Early identification of conditions relating to sight is not directly covered in the relevant NICE guidelines and no recommendations are presented relating to the suggested area for quality improvement area.

Recommendations from the development source relating to the suggested improvement areas have been provisionally selected and are presented below in inform QSAC discussion.

a) Reduction of the impact of sensory impairment

Mental wellbeing and older people. NICE public health guidance 16 (2008).

NICE PH16 Recommendation 1 Occupational therapy interventions

Who should take action?

- Occupational therapists or other professionals who provide support and care services for older people in community or residential settings and who have been trained to apply the principles and methods of occupational therapy.

What action should they take?

- Offer regular group and/or individual sessions to encourage older people to identify, construct, rehearse and carry out daily routines and activities that help to maintain or improve their health and wellbeing. Sessions should:
 - involve older people as experts and partners in maintaining or improving their quality of life
 - pay particular attention to communication, physical access, length of session and informality to encourage the exchange of ideas and foster peer support
 - take place in a setting and style that best meet the needs of the older person or group
 - provide practical solutions to problem areas.
- Increase older people's knowledge and awareness of where to get reliable information and advice on a broad range of topics, by providing information directly, inviting local advisers to give informal talks, or arranging trips and social activities. Topics covered should include:
 - meeting or maintaining healthcare needs (for example, eye, hearing and foot care)
 - nutrition (for example, healthy eating on a budget)
 - personal care (for example, shopping, laundry, keeping warm)
 - staying active and increasing daily mobility

- getting information on accessing services and benefits
 - home and community safety
 - using local transport schemes.
- Invite regular feedback from participants and use it to inform the content of the sessions and to gauge levels of motivation.

Depression in adults with a chronic physical health problem. NICE clinical guideline 91 (2009).

NICE CG91 Recommendation 1.3.1.5 Case identification and recognition

For patients with significant language or communication difficulties, for example patients with sensory impairments or a learning disability, consider using the Distress Thermometer¹⁹ and/or asking a family member or carer about the patient's symptoms to identify possible depression. If a significant level of distress is identified, investigate further.

Dementia. NICE clinical guideline 42 (2006, amended 2011).

NICE CG42 Recommendation 1.1.1.4 Diversity, equality and language

Health and social care staff should identify the specific needs of people with dementia and their carers arising from ill health, physical disability, sensory impairment, communication difficulties, problems with nutrition, poor oral health and learning disabilities. Care plans should record and address these needs.

c) Responsiveness of residential care home staff to the specific needs of people with physical conditions

Dementia. NICE clinical guideline 42 (2006, amended 2011).

NICE CG42 Recommendation 1.1.1.4 Diversity, equality and language

Health and social care staff should identify the specific needs of people with dementia and their carers arising from ill health, physical disability, sensory impairment, communication difficulties, problems with nutrition, poor oral health and learning disabilities. Care plans should record and address these needs.

NICE CG42 Recommendation 1.1.7.2 Management and coordination of care

Care managers and care coordinators should ensure that care plans are based on an assessment of the person with dementia's life history, social and family circumstance, and preferences, as well as their physical and mental health needs and current level of functioning and abilities.

¹⁹ The Distress Thermometer is a single-item question screen that will identify distress coming from any source. The patient places a mark on the scale answering: 'How distressed have you been during the past week on a scale of 0 to 10?' Scores of 4 or more indicate a significant level of distress that should be investigated further. (Roth AJ, Kornblith AB, Batel-Copel L et al. (1998) Rapid screening for psychologic distress in men with prostate carcinoma: a pilot study. Cancer 82: 1904–8)

6.3 *Current UK practice*

Stakeholders reported that while it is not clear that residents of care homes receive less support than people not in care homes, there is evidence that, in general, people diagnosed with sight loss do not receive the psychological support they need.

Stakeholders highlighted research that suggests lack of priority is given to sight loss in care homes with some occurrences of a lack of awareness or interest from care home staff in aiding vision for residents with sight problems that are already detected. In particular, incorrect use of glasses and other corrective aids, such as wearing the wrong glasses for an activity or mixing up glasses for different residents.²⁰

Stakeholders highlighted research by the Royal College of Nursing which involved surveying care home staff. The research found that 48% of care home staff surveyed agreed that residents are accepted in spite of them having needs that the care home may be inadequately equipped to meet. It was felt that this is because homes need to fill vacant places²¹.

A report by the Mental Welfare Commission for Scotland found a lack of physical health checks and offers of screening tests was common in hospitals and care homes. The report points out that people with disabilities have the right to the highest possible standard of physical and mental health (UN Convention on the rights of persons with disabilities). The report recommended that GP Practices covering care homes should be asked about undertaking routine annual health checks for residents²².

Specialist committee members and stakeholders referred to the research report *A World of Silence*²³ produced by Action on Hearing Loss. The findings of the report confirmed that if people's hearing loss is managed effectively in care homes their quality of life can be improved. However, the findings also identified a trend of hearing loss not being diagnosed and managed properly in care homes. Additionally, staff in care homes were found to have very limited understanding of the products available to aid people with hearing loss.

²⁰ Watson J, Bamford SM. Undetected sight loss in care homes: an evidence review (2012). International Longevity Centre – UK.

²¹ Royal College of Nursing (2012) [Persistent challenges to providing quality care: An RCN report on the views and experiences of frontline nursing staff in care homes in England.](#)

²² Mental Welfare Commission for Scotland (2011) [Summary of outcomes from focussed visits 2010-11.](#)

²³ Action on Hearing Loss (2012) The [case for tackling hearing loss in care homes.](#)

7 Suggested improvement area: individualised care

7.1 Summary of suggestions

Stakeholders highlighted the importance of individualised care for the well-being of people in residential care. This included focussing on individual preferences and aspirations, tailoring of interventions, and ensuring that people had control over their care.

Specialist committee members also highlighted the importance of person centred and individualised care that utilizes life history and biography to support individual person centered planning. They stated that this is important as it will challenge the potential for people to have their individuality and identity overlooked in collective care settings.

Suggested quality improvement area	NICE guidance
Individualised care	<ul style="list-style-type: none">NICE public health guidance 16 recommendation 4 (Training)

7.2 Selected recommendations from development source

The provision of individualised care is not directly covered in the development sources.

However, below are those recommendations related to training from the NICE PH 16 guidance on mental well-being and older people. Please note, these are not specific to people in residential care alone.

It should also be noted that this area of care is very much addressed in the two published NICE Quality Standards on patient and service user experience; again, though these are not specific to people in residential care, but patients and services users in the NHS.

Mental wellbeing and older people. NICE public health guidance 16 (2008).

NICE PH16 Recommendation 4 Training

Who is the target population?

- Health and social care professionals, domiciliary care staff, residential care home managers and staff, and support workers, including the voluntary sector.

Who should take action?

- Professional bodies, skills councils and other organisations responsible for developing training programmes and setting competencies, standards and continuing professional development schemes.
- NHS and local authority senior managers, human resources and training providers and employers of residential and domiciliary care staff in the private and voluntary sector.

What action should they take?

- Involve occupational therapists in the design and development of locally relevant training schemes for those working with older people. Training schemes should include:
 - essential knowledge of (and application of) the principles and methods of occupational therapy and health and wellbeing promotion
 - effective communication skills to engage with older people and their carers (including group facilitation skills or a person-centred approach)
 - information on how to monitor and make the best use of service feedback to evaluate or redesign services to meet the needs of older people.
- Ensure practitioners have the skills to:
 - communicate effectively with older people to encourage an exchange of ideas and foster peer support
 - encourage older people to identify, construct, rehearse and carry out daily routines and promote activities that help to maintain or improve health and wellbeing
 - improve, maintain and support older people's ability to carry out daily routines and promote independence
 - collect and use regular feedback from participants.

7.3 Current UK practice

No supporting information on variation in practice was provided.

8 Suggested improvement area: personal identity

8.1 Summary of suggestions

Stakeholders highlighted personal identity as an important area for quality improvement. More specifically they highlighted: having a sense of pride; interest in physical appearance; and maintenance of sexuality.

Suggested quality improvement area	NICE guidance
Opportunities to maintain personal identity	<ul style="list-style-type: none">• NICE clinical guideline 42, recommendation 1.1.5.1 1 (Impact of dementia on personal relationships)• NICE public health guidance 16, recommendation 2 (Physical activity)

8.2 Selected recommendations from development source

Recommendations from the development source relating to the suggested improvement areas have been provisionally selected and are presented below in inform QSAC discussion.

a) Opportunities to maintain personal identity

Dementia. NICE clinical guideline 42 (2006, amended 2011).

NICE CG 42 - Recommendation 1.1.5.1 Impact of dementia on personal relationships

At the time of diagnosis and when indicated subsequently, the impact of dementia on relationships, including sexual relationships, should be assessed in a sensitive manner. When indicated, people with dementia and/or their partner and/or carers should be given information about local support services.

Mental wellbeing and older people. NICE public health guidance 16 (2008).

NICE PH16 Recommendation 2 Physical activity

Who is the target population?

- Older people and their carers.

Who should take action?

- Physiotherapists, registered exercise professionals and fitness instructors and other health, social care, leisure services and voluntary sector staff who have the qualifications, skills and experience to deliver exercise programmes appropriate for older people.

What action should they take?

- In collaboration with older people and their carers, offer tailored exercise and physical activity programmes in the community, focusing on:
 - a range of mixed exercise programmes of moderate intensity (for example, dancing, walking, swimming)
 - strength and resistance exercise, especially for frail older people
 - toning and stretching exercise.
- Ensure that exercise programmes reflect the preferences of older people.
- Encourage older people to attend sessions at least once or twice a week by explaining the benefits of regular physical activity.
- Advise older people and their carers how to exercise safely for 30 minutes a day (which can be broken down into 10-minute bursts) on 5 days each week or more. Provide useful examples of activities in daily life that would help achieve this (for example, shopping, housework, gardening, cycling).
- Invite regular feedback from participants and use it to inform the content of the service and to gauge levels of motivation.

8.3 Current UK practice

The Care Quality Commission has produced the report *Time to listen in care homes: dignity and nutrition inspection programme (2012)* which details some current practice in care homes. The report states that inspectors found many examples of good care being provided by care homes to help make sure that people's dignity is respected. It was found that homes meeting the standards promoted a culture of care that puts residents first. This involved staff having a clear understanding of the preferences and care needs of residents. Staff also saw residents as individuals and supported them to live as independently as possible²⁴.

However, there were also some less positive findings. For example, people living in one in six of the care homes (80 homes) that were inspected did not always have their privacy and dignity respected or were not involved in their own care. Staff and managers in some homes: did not find out how people preferred to be cared for or spend their time; failed to provide choices of activities and options for people to support their independence²⁵.

²⁴ Care Quality Commission (2012) [Time to listen in care homes: Dignity and nutrition inspection programme](#).

²⁵ Care Quality Commission (2012) [Time to listen in care homes: Dignity and nutrition inspection programme](#).

9 Suggested improvement area: involvement of families

9.1 Summary of suggestions

The need to ensure that families are able to stay involved with the life of the person in the residential home was proposed as an area for quality improvement. However, this was specifically noted as of particular importance for people with dementia.

Suggested quality improvement area	NICE guidance
Involvement of families	<ul style="list-style-type: none">• Not directly covered in relevant NICE guidelines and no recommendations are presented

9.2 Selected recommendations from development source

Involvement of families is not directly covered in the relevant NICE guidelines and no recommendations are presented relating to the suggested area for quality improvement area.

It should also be noted that this area of care is very much addressed in the NICE Quality Standards on patient and service user experience; again, though these are not specific to people in residential care, but patients and services users in the NHS.

9.3 Current UK practice

No supporting information on variation in practice was provided.

10 Suggested improvement area: environmental factors

10.1 Summary of suggestions

Stakeholders highlighted the importance of environmental factors for the well-being of people in residential care including the design of the living environment and the importance of access to outdoor activities in natural environment. However, the majority of comments were for people with a diagnosed condition, such as Parkinson's disease or dementia. For example, this may involve access to gardens as well carers assisting and encourage outdoor use on a daily basis whenever possible.

Specialist committee members suggested that access to good quality, nutritional, culturally appropriate food as an area for quality improvement. However, this is considered to be addressed by the Care Quality Commission essential standards²⁶ under outcome 5.

Suggested quality improvement area	NICE guidance
Environmental factors	<ul style="list-style-type: none">NICE public health guidance 16, recommendations 2 (Physical activity), 3 (Walking schemes), 4 (Training)

10.2 Selected recommendations from development source

Environmental factors are not directly covered in the development sources.

However, below are those recommendations related to physical activity and walking schemes from the NICE PH guidance on mental well-being and older people. Please note, these are not specific to people in residential care alone.

Mental wellbeing and older people. NICE public health guidance 16 (2008).

NICE PH16 Recommendation 2 Physical activity

Who is the target population?

- Older people and their carers.

Who should take action?

- Physiotherapists, registered exercise professionals and fitness instructors and other health, social care, leisure services and voluntary sector staff who have

²⁶ Care Quality Commission (2010) [Essential standards of quality and safety](#).

the qualifications, skills and experience to deliver exercise programmes appropriate for older people.

What action should they take?

- In collaboration with older people and their carers, offer tailored exercise and physical activity programmes in the community, focusing on:
 - a range of mixed exercise programmes of moderate intensity (for example, dancing, walking, swimming)
 - strength and resistance exercise, especially for frail older people
 - toning and stretching exercise.
- Ensure that exercise programmes reflect the preferences of older people.
- Encourage older people to attend sessions at least once or twice a week by explaining the benefits of regular physical activity.
- Advise older people and their carers how to exercise safely for 30 minutes a day (which can be broken down into 10-minute bursts) on 5 days each week or more. Provide useful examples of activities in daily life that would help achieve this (for example, shopping, housework, gardening, cycling).
- Invite regular feedback from participants and use it to inform the content of the service and to gauge levels of motivation.

NICE PH16 Recommendation 3 Walking schemes

Who is the target population?

- Older people and their carers.

Who should take action?

- GPs, community nurses, public health and health promotion specialists, 'Walking the way to health initiative' walk leaders, local authorities, leisure services, voluntary sector organisations, community development groups working with older people, carers and older people themselves.

What action should they take?

- In collaboration with older people and their carers, offer a range of walking schemes of low to moderate intensity with a choice of local routes to suit different abilities.
- Promote regular participation in local walking schemes as a way to improve mental wellbeing for older people and provide health advice and information on the benefits of walking.
- Encourage and support older people to participate fully according to health and mobility needs, and personal preference.
- Ensure that walking schemes:
 - are organised and led by trained workers or 'Walking the way to health initiative' volunteer walk leaders from the local community

who have been trained in first aid and in creating suitable walking routes

- incorporate a group meeting at the outset of a walking scheme that introduces the walk leader and participants
- offer opportunities for local walks at least three times a week, with timing and location to be agreed with participants
- last about 1 hour and include at least 30–40 minutes of walking plus stretching and warm-up/cool-down exercises (depending on older people's mobility and capacity)
- invite regular feedback from participants and use it to inform the content of the service and to gauge levels of motivation.

NICE PH16 Recommendation 4 Training

Who is the target population?

- Health and social care professionals, domiciliary care staff, residential care home managers and staff, and support workers, including the voluntary sector.

Who should take action?

- Professional bodies, skills councils and other organisations responsible for developing training programmes and setting competencies, standards and continuing professional development schemes.
- NHS and local authority senior managers, human resources and training providers and employers of residential and domiciliary care staff in the private and voluntary sector.

What action should they take?

- Involve occupational therapists in the design and development of locally relevant training schemes for those working with older people. Training schemes should include:
 - essential knowledge of (and application of) the principles and methods of occupational therapy and health and wellbeing promotion
 - effective communication skills to engage with older people and their carers (including group facilitation skills or a person-centred approach)
 - information on how to monitor and make the best use of service feedback to evaluate or redesign services to meet the needs of older people.
- Ensure practitioners have the skills to:
 - communicate effectively with older people to encourage an exchange of ideas and foster peer support

- encourage older people to identify, construct, rehearse and carry out daily routines and promote activities that help to maintain or improve health and wellbeing
- improve, maintain and support older people's ability to carry out daily routines and promote independence
- collect and use regular feedback from participants.

10.3 *Current UK practice*

No supporting information on variation in practice was provided.

11 Suggested improvement area: organisational factors

11.1 Summary of suggestions

Stakeholders strongly emphasised the importance of training for staff employed in residential care homes.

They reported that residential care staff specifically needed training in assessment and referral for psychological therapies. Stakeholders also highlighted the importance of creating a culture of dignity in care homes and taking a person-centred approach.

Stakeholders also suggested that quality of care could be improved by the identification of a senior member of staff who would support staff to promote mental wellbeing amongst older people. The suggestion for identification of senior staff was made in the context of dementia.

Additional areas highlighted by specialist committee members included equality and safeguarding in general terms. However, it is considered that these two areas are addressed by the Care Quality Commission essential standards²⁷.

Suggested quality improvement area	NICE guidance
a) Training	<ul style="list-style-type: none">• NICE public health guidance 16, recommendation 4 (Training)• NICE clinical guideline 123, recommendation 1.3.2.4 (Assessment)
b) Identification of a lead for quality improvement	<ul style="list-style-type: none">• Not directly covered in relevant NICE guidelines and no recommendations are presented

11.2 Selected recommendations from development source

Identification of a lead for quality improvement is not directly covered in the relevant NICE guidelines and no recommendations are presented relating to the suggested area for quality improvement area.

Recommendations from the development source relating to the suggested improvement areas have been provisionally selected and are presented below to inform QSAC discussion.

²⁷ Care Quality Commission (2010) [Essential standards of quality and safety](#).

a) Training

Mental wellbeing and older people. NICE public health guidance 16 (2008).

NICE PH16 Recommendation 4 Training

Who is the target population?

- Health and social care professionals, domiciliary care staff, residential care home managers and staff, and support workers, including the voluntary sector.

Who should take action?

- Professional bodies, skills councils and other organisations responsible for developing training programmes and setting competencies, standards and continuing professional development schemes.
- NHS and local authority senior managers, human resources and training providers and employers of residential and domiciliary care staff in the private and voluntary sector.

What action should they take?

- Involve occupational therapists in the design and development of locally relevant training schemes for those working with older people. Training schemes should include:
 - essential knowledge of (and application of) the principles and methods of occupational therapy and health and wellbeing promotion
 - effective communication skills to engage with older people and their carers (including group facilitation skills or a person-centred approach)
 - information on how to monitor and make the best use of service feedback to evaluate or redesign services to meet the needs of older people.
- Ensure practitioners have the skills to:
 - communicate effectively with older people to encourage an exchange of ideas and foster peer support
 - encourage older people to identify, construct, rehearse and carry out daily routines and promote activities that help to maintain or improve health and wellbeing
 - improve, maintain and support older people's ability to carry out daily routines and promote independence
 - collect and use regular feedback from participants.

Common mental health disorders. NICE clinical guideline 123 (2011).

NICE CG123 Recommendation 1.3.2.4 Assessment

All staff carrying out the assessment of suspected common mental health disorders should be competent to perform an assessment of the presenting problem in line with the service setting in which they work, and be able to:

- determine the nature, duration and severity of the presenting disorder
- take into account not only symptom severity but also the associated functional impairment
- identify appropriate treatment and referral options in line with relevant NICE guidance.

11.3 Current UK practice

Stakeholders referred to a report by the Royal College of Nursing (2012), Persistent challenges to providing quality care, that highlights a number of issues relating to organisational factors²⁸.

In particular, relevant issues around training were raised by respondents. These included concerns about:

- The perceived lack of funding to provide training, particularly to provide anything above and beyond statutory training and more advanced or specialist training.
- A lack of training for care assistants courses which are considered essential in the provision of even basic care.
- If staff attend training, it often leaves the home understaffed. Some staff reported attending training on their days off.
- The high turnover of staff often results in care staff having to support their new employees, and provide training on the job.
- A perception that some organisations' only concern around training is to fulfil Care Quality Commission (CQC) requirements, not to develop their workforce and to provide better care.

One other report stakeholders referred to was The Alzheimer's Society (2013) report: Low Expectations. Some positive findings in this report included staff and family members reporting positive views on staff understanding and training. However, it was found that adherence to standards remains patchy, and staff responding to the DEMSTAF survey reported they want more training²⁹.

²⁸ Royal College of Nursing (2012) [Persistent challenges to providing quality care: An RCN report on the views and experiences of frontline nursing staff in care homes in England](#)

²⁹ The Alzheimer's Society (2013). [Low Expectations Attitudes on choice, care and community for people with dementia in care homes.](#)

Appendix 1 NICE quality standard for supporting people to live well with dementia (QS30: April 2013)

This quality standard covers supporting people to live well with dementia. It applies to all social care settings and services working with and caring for people with dementia. It should be read alongside the [NICE dementia quality standard \(QS1\)](#) which covers care provided by health and social care staff in direct contact with people with dementia in hospital, community, home-based, group care, residential or specialist care settings.

List of quality statements

[Statement 1](#). People worried about possible dementia in themselves or someone they know can discuss their concerns, and the options of seeking a diagnosis, with someone with knowledge and expertise.

[Statement 2](#). People with dementia, with the involvement of their carers, have choice and control in decisions affecting their care and support.

[Statement 3](#). People with dementia participate, with the involvement of their carers, in a review of their needs and preferences when their circumstances change

[Statement 4](#). People with dementia are enabled, with the involvement of their carers, to take part in leisure activities during their day based on individual interest and choice.

[Statement 5](#). People with dementia are enabled, with the involvement of their carers, to maintain and develop relationships.

[Statement 6](#). People with dementia are enabled, with the involvement of their carers, to access services that help maintain their physical and mental health and wellbeing.

[Statement 7](#). People with dementia live in housing that meets their specific needs.

[Statement 8](#). People with dementia have opportunities, with the involvement of their carers, to participate in and influence the design, planning, evaluation and delivery of services.

[Statement 9](#). People with dementia are enabled, with the involvement of their carers, to access independent advocacy services.

[Statement 10](#). People with dementia are enabled, with the involvement of their carers, to maintain and develop their involvement in and contribution to their community.

Appendix 2 NICE quality standard for dementia (QS1: June 2010)

This quality standard covers care provided by health and social care staff in direct contact with people with dementia in hospital, community, home-based, group care, residential or specialist care settings. It should be read alongside the [NICE supporting people to live well with dementia quality standard](#) (QS30), which applies to all social care settings and services working with and caring for people with dementia.

List of quality statements

[Statement 1](#). People with dementia receive care from staff appropriately trained in dementia care.

[Statement 2](#). People with suspected dementia are referred to a memory assessment service specialising in the diagnosis and initial management of dementia.

[Statement 3](#). People newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local area.

[Statement 4](#). People with dementia have an assessment and an ongoing personalised care plan, agreed across health and social care, that identifies a named care coordinator and addresses their individual needs.

[Statement 5](#). People with dementia, while they have capacity, have the opportunity to discuss and make decisions, together with their carer/s, about the use of :

- advance statements
- advance decisions to refuse treatment
- Lasting Power of Attorney
- Preferred Priorities of Care.

[Statement 6](#). Carers of people with dementia are offered an assessment of emotional, psychological and social needs and, if accepted, receive tailored interventions identified by a care plan to address those needs.

[Statement 7](#). People with dementia who develop non-cognitive symptoms that cause them significant distress, or who develop behaviour that challenges, are offered an assessment at an early opportunity to establish generating and aggravating factors. Interventions to improve such behaviour or distress should be recorded in their care plan.

[Statement 8](#). People with suspected or known dementia using acute and general hospital inpatient services or emergency departments have access to a liaison

service that specialises in the diagnosis and management of dementia and older people's mental health.

[Statement 9](#). People in the later stages of dementia are assessed by primary care teams to identify and plan their palliative care needs.

[Statement 10](#). Carers of people with dementia have access to a comprehensive range of respite/short-break services that meet the needs of both the carer and the person with dementia.

Appendix 3 NICE quality standard for Depression in adults (QS8: March 2011)

This quality standard covers the assessment and clinical management of persistent subthreshold depressive symptoms, or mild, moderate or severe depression in adults (including people with a chronic physical health problem).

Note: NICE is aware that there is a wider social context to depression that this quality standard does not directly address but which is acknowledged in the development of this standard. The focus of the standard is on clinical assessment and management as described above.

List of quality statements

[Statement 1](#). People who may have depression receive an assessment that identifies the severity of symptoms, the degree of associated functional impairment and the duration of the episode.

[Statement 2](#). Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression receive regular supervision that ensures they are competent in delivering interventions of appropriate content and duration in accordance with NICE guidance.

[Statement 3](#). Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression record health outcomes at each appointment and use the findings to adjust delivery of interventions.

[Statement 4](#). People with persistent subthreshold depressive symptoms or mild to moderate depression receive appropriate low-intensity psychosocial interventions.

[Statement 5](#). People with persistent subthreshold depressive symptoms or mild depression are prescribed antidepressants only when they meet specific clinical criteria in accordance with NICE guidance.

[Statement 6](#). People with moderate or severe depression (and no existing chronic physical health problem) receive a combination of antidepressant medication and either high-intensity cognitive behavioural therapy or interpersonal therapy.

[Statement 7](#). People with moderate depression and a chronic physical health problem receive an appropriate high-intensity psychological intervention.

[Statement 8](#). People with severe depression and a chronic physical health problem receive a combination of antidepressant medication and individual cognitive behavioural therapy.

[Statement 9](#). People with moderate to severe depression and a chronic physical health problem with associated functional impairment, whose symptoms are not responding to initial interventions, receive collaborative care.

[Statement 10](#). People with depression who benefit from treatment with antidepressants are advised to continue with treatment for at least 6 months after remission, extending to at least 2 years for people at risk of relapse.

[Statement 11](#). People with depression whose treatment consists solely of antidepressants are regularly reassessed at intervals of at least 2 to 4 weeks for at least the first 3 months of treatment.

[Statement 12](#). People with depression that has not responded adequately to initial treatment within 6 to 8 weeks have their treatment plan reviewed.

[Statement 13](#). People who have been treated for depression who have residual symptoms or are considered to be at significant risk of relapse receive appropriate psychological interventions.

Appendix 4 Suggestions from stakeholder engagement exercise

See separate document.