Supporting older people in care homes at night

Diana Kerr, Heather Wilkinson and Colm Cunningham

This report explores the night-time care experiences of residents, relatives and staff in three care homes in Scotland.

Although night-time care forms a significant part of care home provision, little research has focused on this. Night staff are a vulnerable group, receiving less training, supervision and support than day staff, but with high levels of responsibility.

This report examines the perspectives of residents, relatives, staff and care home inspectors. It identifies areas of good and poor practice, and recommends ways to make improvements through a series of interventions.

Issues explored in depth include:

- the role of regulatory bodies in night-time care inspection;
- the role of managers in supervising and monitoring night-time care;
- causes of distress and sleep disturbance amongst residents;
- the need to reduce the number of checks that occurs throughout the night;
- the training of night staff in areas such as dementia awareness and the management of continence;
- guidance on appropriate noise and light levels; and
- strategies for developing more person-centred care at night.

Recommendations are made for care regulators (commissioners), providers, home managers and night-time staff.

The research will be of interest to anyone inspecting, providing or managing care in care homes.

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Contents

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1 What were we interested in?

Background

Residential and nursing homes exist to provide a 24-hour service. However, many research projects have focused on the daytime care and services that residents receive in care homes. The review of the literature indicates that there is a need to better understand night-time care practices. This action research study sought to explore night-time care more closely.

Residential and nursing homes provide support to around 410,000 people (Office of Fair Trading, 2005) over the age of 65 across the UK. Around 15,700 homes are in operation throughout the UK to deliver this service (Office of Fair Trading, 2005). The number of older people living in these services varies throughout the UK from 2.5 per cent in England to 4 per cent in Scotland and Northern Ireland (Alzheimer's Society, 2007a). The prevalence of dementia in residents living in these homes varies according to their classification, from as high as 80 per cent in 'elderly mentally infirm homes', through to 66.9 per cent in 'nursing homes' and 52.2 per cent in 'residential care homes' (Alzheimer's Society, 2007a).

Regulation and inspection

Regulation bodies in each country of the UK are tasked with ensuring that a quality standard of care is provided and informed by a set of care standards. In Scotland, National Care Standards are in place specifically for care homes (Scottish Executive, 2005). 'Care home' is defined in the Regulation of Care (Scotland) Act as 'a service which provides accommodation, together with nursing, personal care or personal support, for persons by reason of their vulnerability or need' (Scottish Executive, 2001, p. 2). Since the implementation of this Act, there have been no legal differences between residential and nursing homes in Scotland. These two forms of provision remain separately identified in the rest of the UK.

Despite a policy emphasis on providing good care options that promote choice for older people (Help the Aged, 2007) and that recognise the need to improve care standards in residential settings (Department of Health, 2001), standards or expectations specific to the provision of care through the night are notably absent from both legislation and policy guidance (Department of Health, 2001; Scottish

Executive, 2001, 2005). The standards describe the overarching principals that must inform the service provided in a care home, but do not make any specific reference to the needs of older people at night. However, subsequent documents have identified some specific areas that require attention at night. For example, the National Palliative Care Standards for palliative care in adult care homes in Scotland (Scottish Partnership for Palliative Care, 2006) state that food, medication and accommodation for relatives should form part of effective palliative care at night.

The care standards for Scotland inform the function of the Care Commission officers who have 'the general duty of furthering improvement in the quality of care services provided in Scotland' (Scottish Executive, 2001). The residential nature of care homes necessarily requires attention to be given to the quality of care of a *24-hour* service. The review of the literature indicates that there is a need for more explicit guidance on standards of care at night.

Night work

Night workers are estimated to account for 20 per cent of the UK workforce (Johnston, 2005). Research indicates a number of issues and risks for night care workers as a consequence of working nights. Night shift health workers are at greater risk of work-related injury than their day shift colleagues (Horwitz and McCall, 2004). Night workers also report insomnia leading to difficulties in concentration and memory (Zammit *et al*., 1999; Rajaratnam and Arendt, 2001). Irregular working hours make it more difficult to maintain regular eating and exercise regimes, which contribute to gastric and cardiac problems (Geliebter *et al*., 2000; Persson and Rtensson, 2006). Problems with digestive disorders, appetite changes and loss or gain in weight are well documented (Knauth and Costa, 1996).

In addition, depression is identified as a considerable problem in people who work night shifts (Skipper *et al*., 1990; Scott *et al*, 1997). The psychosocial consequences of night shift working are significant, with shift workers indicating an increased level of relationship difficulties and divorces (Circadian Technologies, 2004). However, studies have indicated that some staff have a preference towards permanent night work as opposed to rotational working (Brooks, 1997; Burgio *et al*., 2004). Knauth and Hornberger (2003, p. 111) found that 'working time preferences and needs of shift workers may vary considerably, depending on, for example age, gender, personality, children, hobbies and phase of life'. Some studies have indicated that care interventions are of a better quality when carried out by permanent night staff (Teresi *et al*., 1993; Scilley, 1998).

Overall, the literature indicates that night working has a negative impact on individual life expectancy (Grossman, 1997). Guidance does exist on how night staff can respond to the negative impacts of night work (Canadian Centre for Occupational Health and Safety, 2007). Wedderburn (1991) suggested that a light main meal should be taken around midnight and a snack during the 'sleepy hours', i.e. 3am to 4am. Waterhouse *et al*. (1992) specifically suggested that snacks rich in protein rather than carbohydrates should be taken. However, there was no evidence from this study that guidance for night staff on maintaining well-being was known or given to staff.

Staffing levels

There are few clear guidelines on the ratio of staff that should be on duty at night. The Residential Forum produced staffing guidance at the request of the Department of Health which calculated overall care hours required including night staff (Clough 2002). Others have indicated in general that staffing ratios at night need to be 1:10 (Gerdner and Cornelia, 2006).

Education and training

The Department of Health and the Scottish Executive both established requirements that, by 2005, at least 50 per cent of staff in care homes would have achieved a vocational qualification to level two (SVQ in Scotland and NVQ in England). The requirement did not specify that this target was applicable to both night and day staff.

Overall, the literature would indicate that policies and education requirements for care homes focus on daytime activities, and assume these apply equally to a night context. The Scottish Qualifications Authority (SQA) states that competencies should be contextualised to the work setting (SQA, 2005). Scottish Vocational Qualifications (SVQ) unit DK3V 04 (HSC21) on communication and SVQ unit DK78 04 (HSC216) on physical comfort needs both lend themselves to use within the night-time context. Other SVQ level 2 competencies are, however, principally oriented towards tasks that take place during the day (SVA, 2004). There are no explicit competencies that consider the issues of night-time care.

A Social Care Association report in 1992, *The Lost Potential*, identified the need for more specific training for night staff (SCA, 1992). The Social Care Association has recently reported some positive innovations to address the inequalities in the education of night staff. In one area of Wales, the introduction of a 'Night Assessor' will enable more night staff to have access to vocational qualifications (MacLeod, 2007).

More recently, the Alzheimer's Society (2007b) sees staff training as the central element for improving care standards within homes and for challenging the idea of the traditional 'old folks' home. It believes that well trained dementia-specific staff will ensure that care homes operate more as specialist dementia care providers. However, the report makes no specific mention of night-time care (Alzheimer's Society, 2007b)

Sleep and older people

The literature identifies problems with sleep among older people with or without dementia. At least 50 per cent of people over the age of 65 experience difficulty in sleeping (Martin, 2000) and sleep disturbance is common among people with dementia (Fetveit and Bjorvatn, 2002; Cole and Richards, 2005) who can experience *'*40 per cent of their bedtime hours awake and 14 per cent of their daytime hours asleep' (Dewing, 2003, p. 26).

It is not, however, age per se that affects the older person's quality of sleep, but the physical health changes and other factors that can arise as a consequence of older age (Vitiello, 2006). Older people experience disturbance in the deepest type of sleep stages, delayed onset of sleep and fragmented sleep with multiple arousals. They also engage in daytime napping (National Sleep Foundation, 2002; Wolkove *et al*., 2007). Other factors that affect the sleep patterns of older people include restless leg movement (Hickey, 2000), respiratory problems (Ancoli-Israel and Aayalon, 2006) and inappropriate medications (Willcox *et al*., 1994). One or more of these experiences can cause fatigue in older people and affect cognitive function and quality of life (Bruce and Aloia, 2006).

Within the literature available, the primary emphasis in night-time care is on supporting the person in the activity of sleep and this could become the only objective for staff during the night-time period. While sleep has a positive physiological restorative function (Wolkove *et al*., 2007), the night can also be a time when other beneficial activities can be carried out with residents who wake.

Noise and light

Nearly two-thirds of care home residents experience sleep disorders (Avidan, 2006). It is important that night staff pay particular attention to those aspects of the physical environment that residents describe as impacting negatively on their sleep. Fiorentino and Ancoli-Israel (2006) reported that noise levels were a major problem in nursing homes. They found that noise levels increased until midnight, then decreased from 1am to 4am. 'The source of the noise was most often related to nursing staff speaking loudly or staff creating other noise with squeaking medication carts or pill crushing. A minority of the time the noise was caused by participants' (Fiorentino and Ancoli-Israel, 2006, p. 294). Poor noise and light controls can contribute to poor sleep, which in turn can contribute to falls and affect overall concentration and recall (Ancoli-Israel, 2006). The problem of noise levels is exacerbated for people with dementia, who have a decreased ability to filter out unwanted noise (Jacques and Jackson, 2000) and this can lead to increased anxiety and agitation.

Night continence

Incontinence is an issue in residential and nursing home care. Staff anxiety about the management of continence can lead to overzealous checking. Rahman and Schnelle (2002) highlighted the routine practice of checking groups of residents on a two-hourly basis throughout the night. These practices are not found to be effective and can add to night-time disturbance: 'Seventy-six percent of all incontinence care practices result in episode of awakenings' (Rahman and Schnelle, 2002). Schnelle and Ouslander (2006) identify the need for individual care planning around continence needs, which takes into account both the individual needs of the resident and 'the risk of falls and skin breakdown' (Schnelle and Ouslander, 2006, p. 131).

Summary

- Regulatory guidance does not provide explicit guidance on night care.
- Night work has a negative impact on the physical and psychological well-being of staff.
- National vocational standards do not provide specific education on night care needs.

- Quality and structure of sleep can change with age and physical health.
- Noise and light levels can contribute to sleep disturbance in older people with or without dementia.
- Continence management requires individualised care planning.

The literature available indicates that a better understanding of residents' night-time care needs is required. In addition, there is a need for greater clarity on the role of night staff and on the education they undertake to support their specific role. Residents awake during the night have resource implications for a care home, can increase the workload of the night staff and be stressful for all concerned. Nevertheless, night-time can provide an opportunity for effective and sensitive care practices.

Structure of the report

Following a description of the method used in Chapter 2, Chapters 3–6 outline the findings from interviews with members of the Care Commission, night-time care staff, relatives and residents. Chapters 7–9 focus on practice concerns and interventions to overcome these issues. Chapter 10 presents the conclusions and recommendations from the report for the development of night-time practice.

2 What did we do?

The study had two main stages. First, it explored perspectives on night-time care and identified areas of night-time practice in care homes that required improvement. Second, a stage of action research (implementation and evaluation) determined if and how night-time care could be improved through a small number of interventions. The study took place over a 20-month period from April 2006 to November 2007.

Objectives of the study

The objectives of the study were to:

- gather information on the perspectives and practices of Care Commissioners around night-time care and support;
- understand more fully the experience of older people – with and without dementia – at night in care homes;
- understand and map more fully staff approaches to supporting people during the night;
- identify and develop strategies to change practice in areas of concern that may improve the night-time experiences of residents.

Project Advisory Group

The work of the project was supported by a Project Advisory Group (PAG) whose function was to engage in debate and discussion around the methods and findings as they arose. The discussions at this group, which met four times over the 18-month period, have helped form the structure and content of this report. Membership of the PAG is listed in the Appendix.

Stage one: exploring night-time care

Stage one aimed to gather information on night-time care from a number of perspectives. First a literature review was carried out and then a number of interviews were undertaken with Care Commission officers with a responsibility for inspecting care homes. Finally, in stage one, interview and observation work was undertaken in a small sample of care homes. This included observation of care through the night and interviews with staff, residents and relatives. Both aspects of this stage are now described further.

Literature review

The literature review was undertaken principally through use of academic search engines, including Ingenta, Medline and EDSCO, with keyword searches including the terms 'night care', 'sleep', 'care standards night', 'education' and 'night staff'. The findings of the review have been incorporated into the main body of the report rather than described separately.

Interviews with Care Commission officers

Working closely with the Care Commission, we identified a number of Care Commission officers and sought consent from individuals to take part in face-to-face interviews. The eight officers interviewed covered a number of geographical areas within Scotland. The interviews used a semi-structured interview schedule and were digitally recorded, transcribed and thematically analysed by the research team. The analysis of this stage was used to inform some of the questions used in the case example interviews in the care homes. The findings are reported in Chapter 3.

Collaborating with the regulatory bodies

As the findings from the study emerged, additional funding was provided in order to work in partnership with the Care Commission, Commission for Social Care Inspection (CSCI) and Northern Ireland Regulatory Quality Improvements Agency (RQIA). This enabled the researchers to discuss the findings and prepare a discussion paper and relevant information materials to inform inspection of night-time care.

Care home case studies

Case studies were completed with three care homes. Each of the homes was located in central Scotland. (Despite some policy differences across the UK care home sectors, the findings are relevant to practice and policy throughout the UK.)

The three care homes were identified using inclusion criteria based on: a mix of voluntary, statutory and private providers; varied sizes (i.e. based on bed numbers); and an expressed initial willingness by the home managers to take part.

Also significant across each of the three sites was the difference in built environments. One site was an old house that had been adapted, another site was a 1980s' new build and the third site was a combination of an old house with some adaptations and a new-build extension.

Identifying participants and gaining consent

Following formal ethical approval through the National Research Ethics Service (NRES) and the local authority involved, the researchers approached the relevant management of each site to discuss the study and gain access. Night staff and residents were then approached on an individual basis for consent to participate in interviews where appropriate. Leaflets were developed for all participants in the study and were used as a basis to explain the study purpose and the nature of the commitment that would be involved in taking part. A small number of relatives were also asked to take part and they were identified and contacted by the home managers (see Table 1 for breakdown of people interviewed).

Table 1 Breakdown of people interviewed

	Number interviewed
Care Commissioners	8
Residents	8
Managers	6
Direct care staff	22
Relatives	10

Observations and interviews in the care homes

Each care home setting was observed by the researchers, working in pairs, for several night shifts. The interviews with night staff (including managers) and residents were also usually carried out during the night shift period. Observations started an hour prior to the changeover from day to night shift and finished when the morning shift completed the changeover. Structured observations were made using an observation sheet and field notes were also taken by the researchers.

Night-time staff were interviewed, usually individually but on occasion in pairs or as a small group, depending on their preferences and the practicalities involved in finding time on shift. Interviews with managers tended to be one to one. The interviews were informal and allowed for the night care staff to lead the discussion, but a number of set questions were also asked of all interviewees.

Where residents were interviewed, the discussions were informal and conversational, but they did draw on a number of guide questions and prompts.

The relatives were interviewed individually or as part of a group interview. All had a family member currently living in one of the case example care homes. One care home had a well established relatives' group, which was supported and welcomed by the management and staff of the home. The other homes did not have a relatives' group and, overall, relatives were far less involved.

The interview data were collected using audio digital recordings and transcribed verbatim. The thematic analysis of transcripts and of the observations (structured and field notes) was an iterative process that overlapped the period of interviewing and observing. A collaborative approach was taken, with all members of the research team carrying out a detailed review of all transcripts and then identifying key themes, concepts and processes that emerged from the data. The second review of the data by the team examined these themes to identify similarities and differences between the homes (Lofland and Lofland, 1995). The final stage of analysis was to identify key areas of concern in practice in order to inform the next stage of the work.

Stage two: implementation and evaluation

Areas of good practice and a number of identified areas of concern resulting from stage one were used to develop the content and method for stage two. A site-specific action plan was developed for each of the care homes. Each plan highlighted good

practice and proposed areas for action that were designed to improve night-time practices. The relevant action plan was then discussed in face-to-face meetings, first with management to gain their consent to proceed and then with night staff. Through this process of negotiation, a small number of interventions were decided upon and these were put into place for a period of up to twelve weeks in each site. During this period, these interventions were evaluated and a series of interviews with night staff and management were undertaken at the end of the period.

The changes and interventions involved included:

- development and delivery of training on dementia;
- changes to the physical environment;
- changes to the staff practices;
- increased involvement of managers at night.

Throughout this phase, both managers and night staff were asked to keep written records (on sheets provided) of any changes they either implemented or observed. Researchers made visits to the sites to monitor implementation, where possible, although the regularity of these visits was highly varied across the sites. In one site, the visits were monthly but, in others, this was not achieved because of other commitments of the night staff in the homes (including sick leave) and difficulties with communication.

Night staff and managers were interviewed at the end of the implementation phase to determine what changes had been made, how these changes had been achieved and if there were problems either implementing or sustaining the changes. The findings from these interviews, combined with field notes and the written recordings of the night staff and managers, were used to develop a picture of the overall impact of the study. Where case studies are used as illustrations, they are based on actual observations and field notes. The findings from stage two are reported in Chapters 4–9.

3 What is a night in a care home like?

The following is provided as a general picture of a night in a care home. It is not intended to be an accurate picture of any one particular home, nor are any two nights the same in any care home. The intention is to provide the reader, who may not have worked nights in a care home, with a sense of the main characteristics of a typical night.

Between 7 o'clock and 9 o'clock in the evening there will, usually, be a shift change. Day staff start to wind up; this may involve some residents being helped to bed and others being prepared for bed. Usually this will be only a small proportion of the total resident group. There will then be a handover meeting between the two shifts. Usually this will be between the most senior staff from each shift, with other members of staff sometimes in attendance.

Once all of the night staff are on duty the night-time routine begins. This may involve the provision of a hot drink and a snack, often a biscuit or toast, while a senior member of staff does the drug round. After this the process of getting people to bed begins; this involves walking people to their bedrooms or transferring them to wheelchairs to take them to bed. Those who require assistance with washing and changing to night clothes will be helped, while others will get themselves ready. Incontinence pads will be provided where appropriate and put on.

Although most people will probably be in bed by around 10.30, there will be some residents who may not want to go to bed. Some will stay up for an hour or more, while a few will stay up much of the night.

Depending on the regime in the home there will be a 'checking' routine (going into residents' rooms to ensure they are safe and well). This will be carried out ideally with clear guidelines based on individual assessments of need. It may well be, however, that there will be a routine that involves regular checking of everyone at frequent intervals to make sure that they are dry and not at risk of falling out of bed.

During the night some people will get up and walk about, some will get up for the toilet, some will become distressed and require comforting, some will require food and drink. There will also be residents whose illnesses require medical intervention. Night-time is also the time when people are most likely to die.

At around 6 o'clock the morning routine will begin. This may involve another check of people's incontinence pads. It will also involve helping some early risers to get up. Other people may simply require assistance with the toilet and will then return to bed. Some will require help with washing and others may require an early breakfast snack. Many residents will require medication at this time.

Day staff will usually arrive between 7am and 9am depending on the home's regime. There will then be another handover meeting and the night staff will leave.

4 What did Care Commission officers tell us about night-time care?

Across the UK there are national bodies with the responsibility for monitoring and regulating a series of care standards (see Table 2).

Table 2 National bodies responsible for monitoring and regulating care standards

	National body
England	Commission for Social Care Inspection (CSCI)
Wales	Care and Social Services Inspectorate for Wales
Scotland	Scottish Care Commission
Northern Ireland	Northern Ireland Social Care Council (NISCC)

Each national commission registers and inspects all services against National Care Standards. For the purposes of this study the relevant standards are the 'National Care Standards: Care Homes for Older People' (Scottish Executive, 2005).

The findings reported and discussed in this chapter are based on interviews with eight Care Commission officers (CCOs).[1] The officers were responsible for inspections in care homes in both urban and rural settings. Two sets of concerns were raised by these interviews: first, the role and impact of the Care Commission in care home night-time inspection and regulation; second, issues around night-time care that included:

- staffing levels at night;
- training for night staff;
- staff knowledge about dementia;
- staff anxiety about 'what if' situations;
- the environment;
- communication, especially if English was a second language.

1 The views expressed are those of individual CCO's, and do not necessarily reflect the views of the Care Commission.

The role and impact of the Care Commission in night-time inspection and regulation

Despite the 24-hour nature of care, the focus and frequency of night-time inspections appeared to differ from those carried out during the day. This difference was reported as a change in the last four years; prior to this, it was an expectation that every service would have a night-time visit. It now appears that night-time inspections are not part of the routine round of inspections but are made:

> … as and when necessary. If concerns are raised or if officers are not happy, if they have picked up things like the number of falls, or continence issues, or trouble at night. (CCO 4)

Night-time visits were: 'probably not to do with the inspection process but [where] there are complaints' (CCO 4).

CCOs reported that, when they did take place, night-time inspections were carried out during the early part of the night or in the mornings. The timings of the night-time visits were closely related to the CCOs' focus on whether people were being given choice about bedtime and getting up time. This was the issue that was mentioned most frequently as a measure for night-time practice.

Although renumeration is set out in the terms and conditions for Care Commission staff (where Inspectors have 140-hour contracts which include night-time working), some CCOs interviewed reported 'not being paid' as a reason for not carrying out night-time visits. Other reasons given for rarely carrying out night-time visits were that: they were not felt to be as necessary as day-time visits; and night-time visits might cause disturbance to the residents (although staff reported no change in the levels of disturbance among residents during the night visits from the researchers).

A central element of the CCO remit is to provide advice, as well as to monitor and inspect. Within care home settings, well informed advice and guidance on supporting people with dementia is a critical requirement. CCO knowledge of dementia varied widely; some clearly had in-depth knowledge while others had very little. Some also referred to a requirement for dementia training for CCOs. This is critical if CCOs are to give correct advice and support to night staff caring for people with dementia.

Issues identified by Care Commission officers

This list of issues identified by CCOs is related, where possible, to the current relevant Care Standards (Scottish Executive, 2005).

Staffing levels

There was general concern about night-time staffing levels, which were described as 'cut to the bone' (CCO 3) and 'minimal', with 'no slack' (CCO 5) to deal with contingencies. The emphasis is on the provider to decide on staffing levels. Standards at present demand only the minimum number of staff to meet need. Calls for higher staffing ratios are undermined and generally providers will, as a consequence, only 'meet the minimum and not give the extra' (CCO 5).

The low staffing ratio will inevitably have an impact on care provision:

> … night might be the very time that some … one-to-one time might be most needed. (CCO 6)

> … there are not adequate staff to look after people who are wandering at night. (CCO 7)

Commissioners also commented on the need to have balanced staff groups at night; staffing is about not just numbers but also the required skill mix (CCO 7). This is particularly problematic where the pool of night staff is smaller and therefore offers a more limited mix of skills and abilities.

Training for night staff

> Standard 5:8: You will know that by 2005 at least half of the staff who care directly for you will have received basic training in care (at least Scottish Vocational Qualification level 2 or equivalent). (Scottish Executive, 2005)

CCOs acknowledged that this requirement is usually applied to day staff rather than night staff. As a consequence, night staff do not meet the requirements set by this standard.

> There is a limited number of staff … going on training, night staff would be poorly represented in that number, if at all. (CCO 1)

> It *[the 50 per cent requirement for training]* does not differentiate between day and night staff. It's a percentage of the whole group. They *[care homes]* may be meeting the training requirement but it will be a majority of day staff. (CCO 8)

> Standard 5:6: You are confident that at all times the number of staff who are trained and who have the necessary skills will be sufficient to meet your support and care needs. The levels are agreed between the Commission's inspectors and the home owner or manager. (Scottish Executive, 2005)

In addition to the general lack of training for night staff, the CCOs made specific reference to the lack of dementia-specific training and the general quality of training given (although again this usually related to day staff):

> They *[care home managers and owners]* think they are doing well if they send them on dementia training … but it is about different types of dementia, which in a sense is fine, they need a wee bit of knowledge about that but what they actually need is what to do with them. (CCO 7)

This issue is explored further in Chapters 9 and 10, which address the issue of staff training on dementia.

Staff anxiety about 'what if' situations

The CCOs commented that many of the night staff could be vulnerable and anxious about situations that they feared they might not be able to cope with. CCOs described this as 'what if' anxiety: 'What if there is a fire, what if there is an intruder, what if someone falls, what if I cannot cope?' (CCO 8). Such anxiety is exacerbated by the fact that night staff have significantly less contact with management and receive less supervision as a consequence. This, in addition to their lack of training and minimal staffing numbers, creates a potentially vulnerable staff group.

The night-time environment

The importance and impact of the physical environment within homes was discussed. It was clear that some CCOs knew a great deal about the impact of the environment on people with dementia, as the following quote shows:

> You go into the hotel-type services where one room looks like the next and they don't know what to do. They go into the cupboard to do the toilet because that's where they got out of their bed normally and that's where the cupboard was. In the care home it is the other side. And they are just

> totally disorientated. And they don't use the colour imagery or the pictorial stuff in order to give that help. And I think they are a long way from getting that in … I mean the possibilities *[of getting lost and confused]* are endless and yet, to the uninitiated … and I'm sure very well meaning relatives and carers, it's like, well, 'gosh this is really new and kind of like a hotel'. (CCO 7)

However, this level of knowledge was not generally evident among all other CCOs. The environment can be a critical aspect of positive night-time care and should be a part of any audit or inspection. The issue of the environment at night, especially for people with dementia, is dealt with in more detail in Chapter 9.

Communication

Communication as a central part of good care was recognised by the CCOs. One concern around communication was raised specifically in relation to where English was not the first language of the night staff. It was noted that there was an increasing number of care homes where people did not have fluent English:

> It's a big issue … we know it is difficult to recruit people into care services and there are high numbers of people from Eastern Europe and from across the globe that, you know, are coming to Britain and working in care services. (CCO 4)

However, sensitive use of non-verbal communication could often compensate:

> People from different parts of the world who don't have English as their first language, but are incredibly experienced, kind people who have good communication skills other than speech. (CCO 8)

Communication is, of course, a central issue in the provision of effective care and poor or limited communication among staff could lead to problems, particularly for people with dementia. It was also noted as a problem for relatives, especially when they were trying to communicate with staff with a lack of adequate English over the telephone.

Summary

- Care Commission officers play a vital role in ensuring that care services are of an acceptable quality according to established standards and guidance (Office of Public Sector Information, 2001).

- This work should acknowledge that such care services, where residential in nature, should consider the needs of service users over a 24-hour period using a risk-based proportionate approach.

- Although the National Care Standards make no distinction between night and day, the lack of visibility around night-time care within policy and standards can result in inspection, monitoring and advising remits being discharged differently in practice.

- CCOs interviewed reported that, while daytime inspections occur as routine, night-time inspections are generally instigated only when there has been a complaint or some cause for concern.

- CCOs reported that routinely inspections are carried out in the early evening or early morning rather than during the night.

- Issues identified by the CCOs included: low staffing levels in care homes; vulnerability of night-time staff; practical concerns around environments; specific practice issues relating to communication and knowledge.

5 What did night staff and their managers tell us about working nights?

As part of each of the case studies in the care homes, the night-time care staff were interviewed and several night shifts in each home were observed. Interviews were also carried out with managers in each home. This chapter draws on these interviews, field notes and observations, and will address the following key themes:

- reasons for working nights;
- effect of night working on health;
- staffing levels including recruitment;
- the experiences of staff from minority ethnic groups;
- levels and content of staff training;
- staff experience and night-time culture.

Reasons for working nights

The night-time care staff had a number of reasons for working nights. These often related to meeting short-term needs and/or to fitting in with a specific lifestyle or commitments such as studying or caring:

> My husband was terminally ill, so I could leave him in bed until I got home in the morning and you were there during the day, and then by that time it was just a way of life.

Staff who had worked night shift for many years identified a significant impact on their social life. Working at night often precluded their involvement in daytime socialising. Staff who worked at weekends were particularly prone to losing contact with friends and companions. For some staff there was no incentive to change their routine – they had developed a lifestyle that fitted in with the night work and this had endured over an extended period of their lives. Few of the staff had worked in the day, but most expressed reluctance or indeed a refusal to work during the day.

The emerging patterns around night-time working have consequences for care provision. One consequence of the established preference for working at night can be a reluctance to try alternative shift patterns such as an integrated 24-hour shift pattern.

Staff health

Despite night work meeting a clear need and/or preference for the staff interviewed, they also acknowledged that night work was not 'good for your health'. Staff talked about the impact of working nights on various aspects of their health and well-being. Some were aware that working nights caused problems with their circadian function and that this had a number of detrimental effects: 'You don't get as much daylight and that affects your mood'.

Lack of sleep and the disturbance to the circadian rhythm (the brain mechanism that distinguishes day and night) were identified as the cause of concentration problems in a number of areas of their life – in particular the drive home from work. Rogers *et al*. (2001) found that staff were more affected by sleepiness and poor driving skills on the way home after a night shift than after any other shift.

Night staff also identified problems with their digestion and specifically mentioned the occurrence of irritable bowel syndrome. They attributed this to a number of causes, but particularly that:

> You don't have set meal times … at 3 o'clock in the morning you would kill for a chocolate … and in the morning, how do you eat breakfast and then go to your bed? If you're working that night, breakfast is out and by the time you get up what you're looking for is a bit of tea and toast, and then at tea time you think I just can't sit and eat tea, that's not what I am looking for.

It was apparent that the night staff were experiencing a series of mental and physical health impairments as a result of their work patterns. These ranged from minor complaints to serious long-term conditions. There is evidence that long-term night work can have a negative effect on both morbidity and mortality, indeed constant night work could reduce life expectancy by four years (Grossman, 1997). Some workers were aware of this, but even so were not wanting, willing or able to change their shift patterns.

Staffing levels

There are few clear guidelines on care home staffing levels at night. The papers that do exist indicate in general that night-time staffing ratios need to be 1:10 (Gerdner and Cornelia, 2006). This was usually the case, but only just and with no 'slack' in the system. In one home, staff felt that: 'three is a good number for night staff … we have about 40 residents'. Across the homes, difficulties in ensuring adequate staffing levels related to recruitment, cover and shift patterns.

Recruitment

The study found that the homes had clear problems with the recruitment and retention of night-time care staff. The anti-social hours and the consequent impact on people's lifestyle and health meant that organisations struggled to meet their minimum required levels. Sickness and high staff turnover led to the frequent employment of agency and bank staff.

The employment of agency and bank staff

The employment of agency and/or bank staff was routine across the three homes. In one home, the core staff group was only four members, with three of these working at any one time. A high level of agency staff was used to cope with the gaps in the rota. In another site, the size of the staff group was larger, but again there was a small pool to call on for cover and again this resulted in a frequent use of agency staff.

Staff described the use of agency staff as a poor alternative and usually only a superficial answer to the problem of low night staff numbers. The employment of agency/bank staff might ensure that the minimum staff numbers were met, but they did not necessarily provide an adequate level of care. Night staff spoke of the frustration of employing agency staff. They may come for one night only, they may never have been to the home before and may not know the residents. The permanent night staff have, therefore, to spend time showing them the basic care requirements and systems, directing and informing them about basic issues, often knowing that the agency staff member will not return.

The reliance on agency staff at night presents a particular problem because they are expected to take a more central role. They may be half of a pair working through

the night. If the regular staff member has to spend time teaching and informing the agency staff member, this can have a serious impact on the time available for residents:

> They *[agency staff]* are always behind you, I have to give them instructions and they are not able to do much on their own … and they get paid much more than I do.

> I have to explain there is a back lift, and don't make Jane go back to bed and Jessie's room is down here and Peter likes this and not that, and it all takes time and then they may not come back again.

This problem was exacerbated further by the high turnover of staff. In one home, during the study, several night staff stayed only for a matter of weeks or months. These staff would be counted into the permanent rota but were often unfamiliar with the home and the residents, and were not suitably trained. They therefore presented the regular staff with the same issues and problems as the employment of agency staff.

The quality and commitment of agency staff means that there is inconsistency as well as some unacceptable practice:

> Some of them *[agency staff]* are 'I'm just here to cover another person'… some of them hold back … and you really hate having to ask them and they are not wanting to do it and they're not prepared to do it … we have had *[agency]* staff that have basically sat down and that was it.

Alternatively:

> Some of them are very good and fit in no problem … they will say 'is there anything else I can do for you?' … They are prepared to stick with you and be part of a team.

Shift patterns

All the care homes used a rigid rota of shifts – for example, in one home, a team would do Monday to Thursday and another team would do Friday to Sunday. While, to an extent, this accommodated staff preferences, it meant that the teams were fairly static and there was little flexibility or opportunity to move people across shifts. Again, agency or bank staff were used to supplement shortfalls in numbers.

Unlike day staffing, where people were often on a more flexible rota, night-time staff were less able to change shifts and, even if they did, were likely to be with some of the same people, as the pool of staff was so small. A positive consequence was staff knowledge of each other's strengths and weaknesses, which meant they were able to use their various skills to advantage. The benefits of the development of a cohesive team were described as follows:

> That's why we have got set nights. We know each other really well. Which is a big asset …. if X *[member of staff]* was saying to me 'I am worried about so and so'. Then I genuinely would know it *[was a real concern]*, we just know *[each other]* well.

However, the closeness and insularity of the night teams also has a potentially problematic outcome. A small staff group with little or no supervision and limited training has the potential to be uncritical and collusive.

The low staffing levels were seen to be particularly problematic during the early morning period. It was evident that, between 6am and 9am, there was a lot of movement, with people wanting to get up or have a drink, people needing to have their incontinence pads changed or be taken to the toilet. Waking up can also make people distressed or disorientated. This period also coincides with a shift change and the handover meeting. Night staff are consequently under considerable pressure and are unable to adequately meet the needs of residents at this time:

> To let you understand, I've got to make a report for two floors then *[around 6 o'clock]*, if anything happens, or somebody falls, or like if another morning somebody dies, everything is absolutely chaotic. You're on the floor yourself you've got – for instance, I was going up one day and Millie comes out, dead on half past 7, excrement all over the floor – things like that happen all the time.

There was general agreement that the provision of extra staff in the period from 6am to 9am would facilitate a smoother transition between night and day shift, and would provide the extra help required to meet the basic needs of the residents.

The problems with small staff numbers and poor training were illustrated well by the following description from a night nurse. She was on shift with one care worker; other staff were allocated to other parts of the building:

> I think having one carer, it's not enough for me. Last week I went upstairs and I saw her *[resident]*, she wasn't responding, so at that particular time

> I have got to concentrate on this resident, whether I should get the doctor or maybe doing my first aid. Now at that point there is only one carer who is supposed to be checking all the residents and some of them they need two people to be changed. I am worried. I haven't checked so and so, maybe she is soaking wet … but I need to concentrate on this resident, because I cannot trust the carer without my presence … I need to know exactly what is happening. (Night staff nurse)

Some staff felt that the smallness of the staff group, combined with the fact that people often worked on their own with no supervision, left them open to accusations of abuse. In one home this had led to the staff working in pairs:

> I might go into a room to attend to a resident who is probably doing something, and I am trying to change them and put them into bed, then come in the morning report that I did something, like I smacked them. Without a witness it's their word against mine, so that's why normally doing the rounds it's two people at a time.

Such practice exacerbates the poor staffing levels and has the potential to intimidate residents. Among residents who experience the night-time checking as intrusive and threatening, the presence of two people may well increase the fear and anxiety.

Experience of night staff from minority ethnic groups

All the homes had significant numbers of minority ethnic staff, many of whom spoke excellent English and were trained and highly motivated. However, where some of the overseas staff did not have good levels or clear English, this did present difficulties for other staff, relatives and residents.

Communication is a primary and central concern in the effective provision of care, which means that staff who do not have adequate English language skills can present a concern, especially during a night shift when there are fewer staff. The lack of fluent English does not need to be a barrier to good practice if people are able to find non-verbal forms of communication. Indeed, the researchers saw evidence of warm and sensitive practice from staff whose spoken English was not readily comprehensible. There were, however, examples of the lack of English presenting a problem. Some residents identified examples of times when they were not able to understand what staff members were saying.

It was clear that people from a range of minority ethnic groups were a crucial part of the workforce during the night. However, better support can be required to ensure basic levels of communication and cultural understanding are in place to provide good levels of care.

Staff training

Standard 5:7 states:

> You are confident that at all times the number of staff who are trained and who have the necessary skills will be sufficient to meet your support and care needs. The levels are agreed between the Commission's inspectors and the home owner or manager. (Scottish Executive, 2005, p. 23)

Standard 5:8 states that, by 2005 'at least half of the staff that care directly for you will have received basic training in care' (Scottish Executive, 2005, p. 23).

Standard 5:8 is set at Scottish Vocational Qualification level 2. The Scottish Qualifications Authority (SQA) uses the Scottish Vocational Qualification (SVQ) framework to demonstrate staff competence to work within a care home setting. Because this requirement does not differentiate between day and night workers, the target is often met solely or substantially through the training of day staff. Care Commission officers who were interviewed highlighted this as a serious gap in the training requirements of a staff group, as it meant that night staff are not as well trained as those working during the day.

In this study few of the night care staff had had the opportunity to attend training. Most of the staff identified a training need in the area of dementia, yet, in one home, nobody working on nights had received any training on dementia and, in another, only one member of staff had attended a course. Among the night staff employed in the statutory sector, there was a greater take-up of training, but again this was not at the same level as the day staff.

There are a number of structural and attitudinal reasons for this poor take-up. People who work nights often have other commitments during the day that make it difficult or impossible for them to attend courses in the daytime. Additionally, if people have been working through the night, then they are tired and need to go to bed. They are not able to concentrate or even stay awake if attending a day course. Most simply did not attend:

> The company would say somebody is coming to teach about dementia or something like that, they would come in the day.

The organisation needs to pay staff to attend a day course and to employ agency staff if this means that they are unable to do the subsequent night shift. Therefore, training night staff is seen as more expensive as well as logistically more problematic at an organisational and management level.

Where staff had undertaken SVQ modules, they identified that these were usually inappropriate to night-time care, as the emphasis and orientation was on daytime provision and practice. Indeed, there are no explicit competencies that consider the issues of night-time care, yet staff were clear that there was a need to pay urgent attention to the training requirements of night staff. They require the same level of competence and knowledge as day staff.

Staff experience and night-time culture

Night-times are inevitably different from daytimes in care home settings. There is a different culture between the two shifts that is a result of more than staffing levels and training. The daytime shift has not only more and better trained staff but also a level of activity that gives a more open, varied culture. During the day, there are many visitors (including health-care professionals, visiting friends and relatives, and tradespeople), which means that the daytime staff have a sense of engagement with the outside world.

This is not the case for night staff. There are few, if any, visitors and the staff (and residents) are more disconnected from the outside world. This can result in night staff experiencing a sense of isolation and of being less valued by the organisation, which can be compounded by their general lack of training and limited contact with their managers and other staff. Night staff expressed strong feelings about the involvement of the researchers. They talked about the sense of worth they had felt when the researcher had spent time with them and discussed their concerns:

> The night staff said that they felt valued by the researchers' interest in them. They do not generally feel that their perspective is as valued. (Manager)

> It is so good to have the opportunity to talk about our concerns and have someone listen to us. (Night staff speaking for the whole shift)

Staff experienced high levels of 'what if' anxiety, which related to their sense of isolation and of being on their own without direct managerial support. They were concerned about what would happen if there was a fire, if someone needed to go to hospital, if there was an intruder or if there was an emergency:

> During the day we have got enough staff … and most of the residents are in one place … they are downstairs … and there is nobody in their rooms … so it is easy to watch over them.

This is exactly the same 'what if' anxiety that Care Commission officers highlighted (see Chapter 3). It reflects the wider concerns around staff support during the night shift and the level of responsibility placed with the small number of staff.

Care homes cannot function without the presence of night workers. They provide an essential and sometimes difficult service. It is important that their contribution is acknowledged and rewarded. This study has shown that, despite the negative aspects of night work, many workers find satisfaction and reward in the work. The impacts on health and social life can be outweighed by the ability to meet other needs and, for some, night work provides a fulfilling career.

Summary

- Findings evidence a series of problems for the organisation and management of night-time staff.
- Recruitment difficulties result in minimum staffing levels and high levels of agency and bank staff.
- People who choose to work nights usually have personal commitments that make night work more attractive to them.
- The attraction of night work is tempered by the experiences that staff have of poor concentration, poor health and a negative impact on their social life.
- The common use of agency or bank staff is a burden to the core night staff, as replacement staff usually require high levels of instruction and support throughout the night.
- Staff skills in spoken English are not always sufficient for effective communication.

- Night staff receive significantly less training than day staff and have less contact with management and less supervision.
- Night staff often feel isolated and slightly separate from the rest of the organisation.
- Training and supervision are important concerns in ensuring a good quality of care staff.

6 What are the views of residents about night-time care?

The findings reported in this chapter come from interviews with eight residents (four with confirmed diagnoses of dementia). The residents who were interviewed were self-selecting and accessible, and able to give consent at the time of the interview. The readiness and ability of residents to express their views and articulate problems and solutions was an indication of how rich this source of information can be. Despite this, the literature remains relatively free of residents' views and recorded experiences of night-time care. *My Home Life* (Owen and NCHRDF, 2006) does report on the 'testimonies' of those who live in care homes, but people's specific views on their night-time experiences are not elicited. This study sought, to some extent, to begin to fill this gap.

The views of the residents illustrate some of their key issues and concerns around night-time. The findings also serve to underline the issues highlighted elsewhere. The congruence between the residents' expressed views, the observations of the researchers and the data from the staff interviews helped in developing an overall picture of night-time care. The following themes emerged from the interviews with the residents:

- views on staff;
- experiences of 'checking';
- problems with noise at night;
- practices they found unacceptable.

Residents' views on staff

Residents generally commented favourably on the quality of night staff. They gave examples of the way in which night staff engaged with them in a friendly and helpful manner:

> One of the women that does nights here and I like a good book and we swap, I get up and we swap books.

> They're *[night staff]* pretty good. If you need a hand, they're there for you if you want them, and they are there at the dot if you press that buzzer.

Residents also spoke about the more problematic experiences they had of night-time care. One resident thought there was a difference between night and day staff:

> I feel I must be honest; there is a difference *[between night and day staff]*. They *[night staff]* are not so good. They are not of course used to us in a way.

On further discussion, this difference was attributable to the high use of agency staff, which meant that staff did not know the residents and, conversely, the resident did not know the staff member:

> Well unfortunately, of course, they do run short of staff at *[night]* times and sometimes the night staff are from agencies.
>
> Some of them haven't had the experience.
>
> We haven't seen them usually at all you see, we don't know them. And they have to get used to the routine here, which is sometimes quite difficult for them I suppose.

The second main reason for residents' unhappiness with night staff related to gender. The choice of staff (and gender of staff) available to a resident was much more limited during the night because of the smaller number in the staff group. If there was only one man and one woman on duty, and the woman was busy, then the resident would be tended by the man – even if they felt very uncomfortable about this:

> I did ring and he came and I said 'I would rather have a lady please'. 'Oh what's wrong with me?' or something. And I said 'I haven't anything against you. I just would prefer a lady.' It was because I needed to use the toilet I think for something. (Female resident)

Residents of course have no control over staffing situations, but high use of agency staff and limited choice of staff, particularly gender of staff, can generate excessive levels of anxiety and discomfort for them.

Residents' experience of 'checking'

'Checking' was a standard procedure in all of the care homes. It involved a member of night staff going into residents' rooms on a regular basis throughout the night to make sure they were safe and comfortable. Checking was experienced differently by different residents. Those who felt that the checking was kept to a minimum and not intrusive saw it as a reassurance:

> I know they would come and see that you're OK, you know during the night. I just turn over. I know who it is.

> But she just opens the door and looks to see everything's all right and away she goes. It doesn't matter because if I wasn't feeling too great then I could always tell her.

Others experienced it as a source of disturbance or even distress:

> One of the night nurses, the one's that on, sometimes she gets the door open just to see if you're all right. But I'm never usually sleeping but it does disturb me, because I know there's somebody came in my door.

Other residents commented:

> Oh yes, we have got this little old lady who walks up and down here, and what she doesn't bring to me is nobody's business … But sometimes she will just say 'checking'. Well she did the last time. I kind of wakened up, she says 'checking' … some people don't hear her, and I think there's a man now sometimes wanders up and down. I don't know … you get the voice 'just checking' … she is small, a little thing. And somebody said she is quite harmless. I said, 'well maybe she is, I don't know'.

> I am fast asleep and then they open the door and put on the light and I jump awake, my heart jumps and then I cannot get back to sleep.

The following observation highlights the different needs of residents at night. Whereas some people did not want to be disturbed, others welcomed the opportunity for company:

> Resident: Well, they look in and out. They are out so quickly you've not got time to say anything.

Interviewer: Would you like to?

Resident: Yes, well, it's a long time since they talked to me.

One man made a distinction between staff opening the door to check and coming into his room, which he experienced as an invasion of his space. His reaction was somewhat vehement and indicative of strong feelings engendered by the presence of a male member of staff in his room.

> There was one night I was going to give him *[member of staff]* a bloody nose. I was going to punch his face off. And he was going round all the rooms and he opened my door and he was going to walk in. 'Where the hell do you think you are going?' He said, 'I'm just coming to see the room'. I said, 'at this time of night. Get out or else.' And it seemed to put him off.

Problems with noise at night

Night-time noise was related partly to the process of checking, but there were other noises that residents commented on that woke them at night:

> That's one thing at the new building … You hear the noise more than you do in the old building … well you hear people in the corridor, you hear them walking along and that. But I can't hear other rooms. Well it's not … soundproofed the way the other one was *[the old building]*.

People made a number of comments about intrusion and noise from other residents:

> No you never hear anything. One of the ladies has got a habit of knocking at your door, but I'm not the only one she knocks on the door. She's just looking for company I suppose. Well she goes away and sometimes she comes back again, or she's away at somebody else's door. She just cannot go to sleep and she just wanders about.

The following example is worthy of note:

> There was a new lady came in next door and, and she came in and sat on my bed. I was still in bed actually. It was early morning. And I didn't know until they came to make the bed that she'd used it as a toilet *[laughs]*. So that was my worst experience.

Practices the residents found unacceptable

In this section, we outline two examples of practice given to us by residents that they found unacceptable. These examples of insensitive behaviour denied the personhood of the resident:

Resident: And, if someone comes in, they generally do speak but … a woman came in one night quite recently … and immediately put off my television, I was lying in bed watching it you see, and then didn't say anything.

Interviewer: She didn't say anything? She just came and turned it off?

Resident: Yes, she came and put that off and then … I felt perhaps I was a bit, well, not intimidated but, you know, I thought 'oh that was horrible, she should have spoken to me'. And anyway X *[the manager]* said, 'oh she found out that she was from an agency and she didn't know you couldn't do that'. But I would have thought common courtesy would make you say 'now would you mind if I put off your television?'. She just came in to give me my tablet I think or put it down for me and not a word, boom, and she put, and you see the annoying thing about that is I can't put it on with this *[remote control]* once it's been switched off there.

One night, two men came into my room and started raking through the drawers and bang, they make an awful lot of noise these drawers. Anyway it turned out that they were looking for gloves or something. Yes, well, I hadn't seen them before. And the door opened of course. I woke with the lights and … they came in bang, bang, bang, all the drawers.

These examples highlight how staff carrying out what they probably perceive as routine work can cause considerable distress to residents. Staff need to consider how they can achieve a balance in undertaking tasks in ways that give primary consideration to the resident.

Summary

- Night-time care can be different from that expected and provided during the day.
- Night-time is not always experienced as a time of peace and quiet. It can be a period of quiet sleep and security, or it can feel noisy and unsafe.
- This is dependent on staff awareness and practices when working through the night.
- Different residents had different needs, perceptions and reactions to staff, the environment and practices.
- Each resident's profile, needs and risk assessment should be recorded, known and taken into account by night staff.

7 What are the views and concerns of relatives?

The following themes emerged from the interviews with the ten relatives. Their:

- anxiety about what happens at night;
- lack of knowledge about what goes on at night;
- views on the inspection of night-time care.

Anxiety about what happens at night

Relatives' anxieties about what happened at night were very similar to the 'what if' concerns expressed by night staff and Care Commission officers:

> What if there was a fire or another emergency? There are not enough staff to get everyone out.

> Unless they are superheroes, they will never get them out in a fire. There's no way two people are coping with all these people and a fire.

The fact that none of the relatives had actually asked about the procedure was, perhaps, indicative of a fear about what they would be told:

> And that's, that's my worry and again I think maybe that's why we don't ask because we don't want to know really.

This response is interesting because it was made by a relative, and agreed with by others in the group, who had no hesitation about checking the practices and procedures for daytime care. The level of anxiety relates perhaps to their lack of knowledge about night-time practices.

Lack of knowledge about night-time care

Relatives talked extensively about their lack of knowledge about what happens during the night. Although they all spent time in the homes during the day, and so were able to see what types of practice were in place, they had no idea what the night-time routines and interventions were:

> When my mum first came in, I had no idea what was happening at night and she was very unsettled you know. She was still fairly mobile then, quite a few problems but I didn't know what was going on at night. And it always used to worry me a bit because my mum was quite a handful too.

This led to a sense that there was another world that their relative entered at night, to which they were not party. Concerns were exacerbated as relatives did not know night staff (as they did not visit in the evening). One asked the researcher if the night staff were 'good, nice people?'. Overall, relatives felt that they were 'in the dark' about night-times. They suggested that having photographs of night staff on display would at least give them a sense of who was there and they talked about the possibility of coming in at night themselves:

> I think not knowing them *[night staff]* is a lot of our fault because we come in during the day.

While they were clear that 'I don't think anybody would stop you coming in at 10 o'clock at night', they recognised that, as they were in during the day, this would be a considerable extra commitment. Communication with night staff seemed difficult and one relative who had tried to talk to them described the following experience:

> I phoned one night when we were away and it was when the night staff were on. And I never did it again because it was a chap that I spoke to, I don't know who it was. But, you know, when I spoke about my mum you just sort of felt he gave me a standard answer. And I thought 'I don't think he really knows my mum'. I started to worry about it then. And I thought 'no I just can't, I can't do this'.

The problem with communication clearly centred on the fact that relatives did not meet night staff. This is illustrated by the relative who only discovered about her mother's night-time needs – and staff management of these – through the casual contact with a night staff worker on a day shift:

> But I knew nothing about night. But I kind of found out by default what was going on because a member of the night staff was doing a, just an extra shift in the laundry during the day. And, as we were going past, I didn't know she was obviously a night staff. But she said, 'oh hi' to my mum. And said to me, 'oh your mum's a character, you know'. And she then started chatting. It was very reassuring, hugely reassuring. It was just nice to know that there's nice people on at night.

Use of agency staff in the day did not seem to present a worry to relatives, as they thought that staff numbers could compensate for any shortfalls in agency staff's understanding of their relatives' needs. Relatives recognised that, at night, there were fewer staff and that the impact of agency staff was potentially more damaging. The relatives expressed an anxiety that an agency staff member may be one of only two on a floor and that their lack of understanding and knowledge about their relative could be very harmful.

Relatives' views on the inspection of night-time care

Relatives expressed great concern that night-time inspections occurred only if there was cause for concern or a specific complaint. They recognised that night-times do not necessarily bring calm and sleep to their relative, but that 'the problems that residents have in the day won't go away at night-time.

To an extent, the 'what if' anxiety was increased by the sense relatives had that residents were not being given the same level of attention and value at night as they were during the day. Relatives' concern that there would be problems if an emergency occurred meant they wanted tighter controls and inspections at night. Whether such inspections would lead to any safer night-time emergency practice is debatable.

Summary

- The positive relations fostered with relatives in one care home were clearly to the benefit of all concerned. The regular 'relatives' group' meetings for information giving and socialising provided relatives with information and support. This provision could be well used in other homes (Woods *et al.*, 2007).

- Overall, there remained a marked lack of involvement in, and knowledge about, night-times from relatives.

- Relatives perceived there were fewer opportunities to get involved at night because they believed people were generally asleep at night.

- Relatives did express a desire to know more about the staff who were on duty at night and to have some form of communication with them about their family member.

- Relatives expressed concern that the same level of inspection was not in place for nights as it was for daytimes. They wanted this safeguard in place.

8 What are the key concerns for practice?

This chapter is based on findings from interviews with staff (night care staff and managers), residents and relatives, as well as direct observation during night shifts.

Examples of sensitive and considered person-centred practices were observed throughout the study. Despite the shortfalls described in the previous chapters, many members of staff were able to overcome the difficulties. They found time to provide a supportive service, which showed an understanding of the needs of the resident and an ability to respond with warmth and care that respected the person's dignity and choice.

Case example: Mary

Mary was a frail woman of 98 years, but with a strong sense of what she wanted. She was determined not to be told what to do. She did not want to go to her bedroom at night, preferring to be downstairs where she could see people and not feel alone. Staff members would, throughout the night, check that she still wanted to be left in the lounge. They made her comfortable, provided refreshments and talked to her when she showed signs of being awake and wanting company. Recognising that this woman ate very little during the day, staff would give her food throughout the night. ('Give me something to eat, put it in my right hand', she would demand.) She would then go back to her chair and sleep for a while.

The staff realised that Mary would have benefited from the provision of a reclining chair. This would have made her night vigil more comfortable and might also have aided sleep. Although this had been requested by the night nurse, nothing had been provided during the time of the study.

While Mary's case is an example of staff warmth and sensitivity to residents, it also illustrates how the focus of homes is on daytime care. It seemed to be assumed that at night people would be in bed. The provision of reclining seats so that residents could stay close to staff at night if they wanted to had not been addressed, even though this would be a positive practice.

The main practices identified as requiring attention were:

- management involvement in night-time supervision and practice;
- the frequency and nature of 'checking';
- noise levels;
- light levels;
- staff understanding and response to people with dementia;
- staff understanding and response to issues around incontinence;
- the physical environment;
- relationships between day and night staff.

Management involvement in night-time supervision and practice

Many of the home managers were unaware of some of the common night-time care practices. The various examples given below are an illustration of how some night-time practices can become entrenched without management agreement or awareness. Some are illustrative of how night staff will begin to reinterpret the policy through lack of contact, supervision and training. The outcomes are then not what management had intended. This shift in practice can happen within institutions at any time, but the isolation and lack of supervision of night staff exacerbates the situation and makes such distortions of management policy more likely.

In all of the homes there was minimal management presence or supervision throughout the night. There was a feeling among night-time staff that, even where managers did spend time in the home during the early evening, this did not give them sufficient information about night-times. The early evening and indeed the early morning represent particular phases of the shift, but they do not provide a complete picture:

> The remit of the management *[should be]* to assess the level of our workload, comparing the level and the burden of care by the day staff and the night staff … because they will see for themselves what is the reality. (Night staff)

There was a general feeling that managers knew more about the daytimes than the night-times and that this placed night staff at a disadvantage. Managers were not totally absent; in fact one manager carried out routine night staff appraisals during the course of this study. It is not, therefore, that managers are totally invisible at night, rather that their presence is task specific, for limited periods and they are not seen as part of the staff group in the same way as they are during the day.

Staff expressed the feeling of being, to varying degrees, isolated from management and less valued than day staff. As a consequence, they felt they missed out on communication about the general running of the home. Managers themselves identified that they were not as well informed about night-time practices as they were about those in the day.

‘Checking’: frequency and nature

Standard 16:1 states:

> You have control over who goes into your room or living space, and when this happens. Your door will have a locking system that you can use but staff will be able to open it if there is an emergency. (Scottish Executive, 2005)

Standard 9:5 states:

> You are assured about your safety from intruders by knowing that the home has a system where all visitors need to get permission before they can enter. (Scottish Executive, 2005)

Despite clear messages around privacy and safety, ‘checking’ remains an activity that occupies much of the night staff’s time and energy. The main reasons given by staff for entering a resident’s room were to check for breathing, continence, falls and turning. The practice of checking residents at night is a measure of the pressures that night staff can experience, as well as an indication of a lack of training and support.

The homes had varying practices in relation to checking. These ranged from opening the resident's door to check for breathing, to turning on the light and calling the resident and then taking down the bed covers to feel or look to see how wet their incontinence pad was. In one home, the latter was occurring on the night shift every three hours. This was done regardless of a resident's level of incontinence:

> You open the door … Turn the lights on … you are going to wake them up because you are going to check the pad, if it's dry or wet. There are some heavy-duty ones *[pads]*, they can actually probably hold up to quite a few litres, so you can probably say some of them won't be that wet, but we have still got to change them and wash them, that's the policy. Everybody is using pads at night, so all get checked, every three hours … usually 12 o'clock everybody is checked, then 3 o'clock and then at 6 o'clock. (Night staff)

The checking was done in pairs in some homes, partly to aid lifting and partly for 'safety' against a perceived risk from staff that complaints could be made against them.

In another home checks were conducted every hour. Following an incident elsewhere where a resident had not been checked and had been found on the floor in the morning, the manager had instigated the hourly checks. This level of checking was not one that the trained staff were comfortable with – they recognised that it was intrusive and often counter-productive. This type of response where one incident leads to an overprotective approach is, of course, a potential feature of any institution. The resultant practice creates a tension between protection and a practice that actually causes residents distress and can increase the likelihood of agitation.

The distress and agitation caused to residents by their experience of checking as intrusion was expressed by those with and without dementia. What is clear is that, even when the staff were only opening the door to check for breathing, they were disturbing the resident. The click of the door is enough to awaken a light sleeper.

There is, of course, an imperative that staff check vulnerable people who are at risk of falling or dying, who are so incontinent that their pads no longer work, or who need turning. In this context, it is essential that managers give clear messages and are aware of what actual practices are operating through the night. One manager, while approving of frequency of checking, was not aware of the extent or intrusive nature of the checks. Guidance from the management about the frequency and requirements for checking should be clear and informed by individual risk assessments for night time. Such guidance will reduce the confusion around management expectations of the need for checking, and the 'what if' anxiety of staff described in Chapter 5.

Clearly Standard 16:1 was not generally being applied through the night. Standard 9:5 relates to intruders from outside of the home. However, it applies equally to the experience of being intruded on, uninvited, by a stranger within the home – as the following case example shows.

Case example: Caroline

Caroline was fast asleep in her room. She had been sleeping from about 11 o'clock. At 2am a staff member opened her bedroom door, turned on the main light and called out in a loud voice, 'Caroline, wake up now, I have come to check you'.

Caroline cried out. The nurse did not continue to speak or reassure her, but simply went into the now brightly lit room and made a check of Caroline's incontinence pad.

This case example demonstrates that checking should be more than a practical task. It should involve an interaction between staff and resident, with the person being treated as an individual and not just seen as a task to be completed. The issue is not simply about whether the checking is necessary but also about the manner in which it is carried out. Although there was evidence of this being done with sensitivity and care, sadly the above example was not unusual.

Noise levels

Standard 4:3 states:

> You can expect that the premises are kept free from intrusive sounds throughout. (Scottish Executive, 2005, p. 19)

High noise levels at night were commented on by residents and observed by the researchers. Some noise is, of course, inevitable and unavoidable. It would be impossible to have a noise-free environment in a setting with 20 or more people and where nursing and caring activities need to take place. However, there were often high levels of unacceptable and avoidable noise. The main causes that were identified were:

- staff talking loudly;

- staff activities;
- buzzers/resident alarm systems;
- residents;
- the fabric of the building.

Noise made by staff talking

While some staff clearly made great efforts to keep their voices down and to conduct conversations away from residents' bedrooms, others failed to do so. As they moved around the building they would talk outside people's rooms and call to each other down the corridor. They also simply talked too loudly, at a volume that would be normal during the day. It was observed that the noise level made by staff talking and other activities increased towards the morning.

Noise made by staff activities

Obviously, the need for staff to carry out nursing and caring activities created noise. While some staff made an effort to keep this noise to a minimum, others were not so sensitive. Opening and shutting doors, taking the laundry trolley along corridors, the creaking of floorboards as they did their rounds all created a level of noise that was often disturbing to residents.

> And it is so true about the noise, because one night there was a nurse – a lovely nurse – but she came down with a big trolley and it sounded like thunder, and about five residents got up. (Staff)

Noise of buzzers/resident alarm systems

Where a central alarm system was in use for residents to make contact with staff, the various noises the alarms made (usually a loud buzz or ring) would be disturbing at all stages throughout the night. The buzzer could ring for several minutes before a member of staff got to a resident's room to turn it off, particularly if staff numbers were small. In some settings the buzzer became louder and more insistent after a certain length of time:

> I would change probably the buzzer system … it's just too loud, if somebody is sleeping they could get woken up with that because, sometimes if I am working with a particular resident and somebody is buzzing, if you can't attend to that person at that particular time, it keeps going. We have got to get to the room to cancel it, there is no other way to do it. (Staff)

The placement of the central control box was important – when it was located away from bedrooms it was marginally less disturbing.

Noise made by residents

The sounds made by residents were sometimes difficult to control, especially if a resident was in distress. Where such distress was a result of poor practice or communication problems, there was a need for better staff training, especially in the care of people with dementia:

> Sometimes it's some of the residents that are making the noises … like the man up the stairs. And he shouts non-stop. He can shout for about three hours some nights. You can hear it go through the whole building. (Night staff)

Noise made by the building

There were other noises made by the building as the staff carried out their duties. The sound of plumbing as laundry was done and creaking floorboards occurred throughout the night. Residents spoke of hearing people walking up and down in the corridor. In one home, the researchers walked along a corridor on tiptoe and still two residents came out of their room to see who was there. This is disturbing for anyone but, for people with dementia who may have problems orientating at night and remembering where they are, there is potential for them to fear someone is breaking into their house. It was the newer buildings that presented the most problems, with creaks and lack of soundproofing.

Light levels

In some instances, the lights were turned down in the main sitting areas and in the corridors during the night. In others, this was not always the case and the undimmed lighting did not give a message that this was the night. Bright lights were not conducive to sleep or preparing for sleep.

People with dementia require very clear information about what they are supposed to be doing, as their own cognitive skills will be impaired and unable to compensate for wrong or misguiding information. It is critical that the brain is given clear cues and clues that the time has come for bed and sleep. It was noticeable that the home that had the most people staying up, sometimes all night, was the one that had the lights on full in the main sitting area and in the corridors.

The most problematic aspect was the amount of light that was used when people were being checked. The main switch in the room was often turned on, flooding the room with bright light. Some residents did have night lights on, but often the process of checking involved the staff either leaving the main light on all the time during the checking or turning on the main light until they walked to the side/night light, then turning this on before turning off the main light again. Intermittent exposure to light throughout the night, as with intermittent exposure to noise, is known to contribute to sleep disturbance (Fiorentino and Ancoli-Israel, 2006). The fact that, in these homes, residents were routinely awakened by light and noise disturbance is a cause for concern. This finding is in line with other research (Schnelle *et al*., 1993a, 1993b), which found that 50 per cent of awakenings of more than four minutes in duration were associated with either noise or light. There are changes to the circadian rhythm and other physical and psychiatric and medical interventions that can affect the sleep patterns of older people. Disturbed sleep is not, however, an inevitable part of growing older or of living in an institution. It is important that night-time staff do not see the problems that people have with sleep as inevitable and that they look to environmental contributory factors, such as noise and light levels over which they have control.

Staff understanding and response to people with dementia

Discussions with staff and observations showed that most staff had not had sufficient training in dementia care. Some staff had attended courses, but these had been highly varied in content and philosophy. Some courses had merely described the

condition, while others had contained more detail about appropriate responses. For one staff group the information had come in the form of a leaflet. It was evident that night-time staff needed more information and insight into the impact of dementia on people, especially as it is common for people with dementia to get up during the night mistakenly thinking that it is the morning. Night staff are, therefore, inevitably going to have a high level of interaction with people with dementia. The lack of understanding about some key issues in relation to people with dementia was exemplified by the following case example.

Case example: Jenny and the tea

Jenny was a lady with dementia. She was sitting in the sitting room while staff were getting people to bed. As part of the bedtime routine all residents had been offered a hot drink and biscuit.

Some 20 minutes after the hot drinks had been cleared away, Jenny was sitting on her own watching the activities of staff and residents. She started to ask for a cup of tea. This request was ignored. She asked again and again, but was still ignored.

One of the researchers spoke to her and she again said she wanted a cup of tea. The researcher then went to the staff member on duty and offered to make a cup of tea for Jenny. The staff member stated that it was a waste of time, as she would not drink it. She had dementia and she asked for things but did not necessarily want them. The tea would go cold and would be left.

Reluctantly, the staff member made Jenny a cup of tea and gave her two biscuits. The tea was placed on a small table at the side of Jenny's chair. She dunked her biscuits in the tea and sucked the tea off them. She did not lift the cup, which was at an awkward angle to her, and was soon distracted by all the activity in the room. She seemed to forget the tea was beside her.

The cold tea was later taken away and was shown to the researcher as verification of the fact that it was not wanted and would not be drunk.

Jenny had clearly wanted the tea and had enjoyed sucking the moisture from the biscuits, but she had been easily distracted and, because the teacup had been placed at her side, she had forgotten it was there. If staff had placed the cup in front of her and if they had every so often reminded her that it was there and that she would need to drink it before it got cold, Jenny might well have consumed the whole cup. She might also have enjoyed it.

This example illustrates the need for better understanding by the staff of the impact of dementia on people's ability to drink (VOICES, 1998) and the challenge of maintaining hydration among people with dementia in care settings. Despite a substantial evidence base to guide practitioners (NHS Scotland, 2002; Caroline Walker Trust, 2004), malnutrition and dehydration are serious and common problems among older people in care homes (Copeman, 2000; Cowan, 2003). Care standard 13 specifically relates to eating well and has ten substandards that relate to a range of food, nutrition and hydration practices, with substandard 13.5 in particular stating: 'You can have snacks and hot and cold drinks whenever you like' (Scottish Executive, 2005).

Supporting good practice around such standards requires good information and training. Night staff had received poor levels of training and information about the impact of dementia and little useful information about appropriate responses. They will inevitably need to care for, and support, people waking during the night. Lack of understanding and insight into the experiences of the person with dementia, their different reality, their problems with eating and drinking, their problems with orientation and mobility are central to good practice. Without this knowledge, night staff are left ill-equipped and may engage in practices that, at the very least, are not helpful to the person with dementia – and at worst are harmful.

Staff understanding and response to incontinence

Caring for residents' continence needs was a central concern for the night staff. A key reason for checking residents through the night was to ensure that they were dry. The checking for continence levels was done by pulling back the bedclothes and looking at the pad to see how much of the strip had changed colour (indicating the level of moisture being held by the pad). Pads were sometimes changed even when the colour change indicated that they were not full or causing any distress.

All three sites in the study required that continence pads were checked regularly and indiscriminately, and that they were changed even if they had not been fully used. This practice was the consequence of a number of factors.

- There was a frequently expressed fear that residents would be left all night in wet pads.

- Few night staff had been given any training on how to manage incontinence. Training had been provided in one home but it was during the day and therefore

not easily accessible for night staff. Another home described an information session by a representative from the company that supplied the incontinence pads as 'training'.

- Night staff often felt that they were open to criticism, especially from day staff, about the extent to which pads had been left on while wet.

- In some cases, the day staff ordered the pads and these were not always suitable for the management of night-time incontinence. Night staff expressed frustration that the person ordering pads did not recognise the different management issues at night and adequate communication systems were not in place.

Case example: Morag

A male member of staff entered Morag's bedroom. She was fast asleep but, as the light was put on and she was called, she woke to find a man in her room. Half-asleep and probably dazed she then had the experience of a man she did not recognise (because she had dementia) pulling back the bedclothes and taking off her pad.

She screamed 'leave me alone, help, help'.

It is possible that, as often as three times each night, Morag was having an experience that terrified her. It may well have been that her level of incontinence made it necessary to change her pad three times, though equally it may simply have been part of a routine. Certainly staff should have tried to ensure that a female had changed her and the manner in which she was changed could have been accomplished with more sensitivity.

Where high levels of incontinence are present and where the pads cannot contain the moisture, it is essential that they are changed and the person made comfortable. However, routine checking without detailed individual assessment means that everyone is being checked and the consequence of this extends beyond the mere act of changing a wet pad.

Incontinence is a substantial area of concern for staff in care homes, as a high proportion of residents will have some level of incontinence. It is essential, therefore, that night staff have specific training on the management of continence. Input is required from a specialist nurse who can give specific night-time advice.

The physical environment

Many of the features necessary for a suitable and positive physical environment in care homes are relevant to day as well as night. It was evident that none of the homes had been designed to incorporate features that would enable, facilitate and reduce risk for people with dementia. The environments were, at the least, unhelpful to residents with poor eyesight, mobility problems and hearing difficulties. The areas that were most problematic for residents were:

- orientation and visibility;
- flooring;
- mirrors and reflective surfaces;
- hazards.

Orientation

All of the homes had large communal sitting areas and often long or twisty corridors. These presented more as hotel-type accommodation and consequently were not particularly homely, although there were features in some that were welcoming. Residents were often heard to say, 'I'm going home'. Although there are many reasons why people with dementia are so frequently 'going home,' the existence of buildings that look like hotels, hospitals and other places of transition will increase the chances of them feeling unsettled, particularly at night when they become agitated and feel the need to 'get home' and to their own bed.

In this study, the toilet and bedroom doors had little visual information that gave clues about what was behind them. Even where there was signage, this was obscured by the dim lighting in the corridors. Usually all the doors in any one establishment were the same style and colour. There was no attempt to have contrast that would enable residents to distinguish doors, particularly toilet doors, from others (Judd *et al.*, 1998). Handrails were often the same colour as the wall, and no toilets used colour contrast to enable residents, and particularly people with dementia, to identify the toilet seat itself (Judd *et al.*, 1998). Long corridors meant that residents coming out of their rooms were presented with a long dimly lit space that did not help to orientate them to the toilets, to shared space or to staff. As a result, they walked about, often distressed, looking for someone to help them.

Flooring

The loss of ability to see three-dimensionally early in the progression of dementia means that people will see patterns on carpets or changes in colour of carpet between rooms as changes in level (Kerr, 2007; Pollock *et al*., 2008). They will then either try to step over something that is not raised or even refuse to go where they perceive a hole.

In this study, residents were seen trying to step over large patterns on the carpet or bending over to pick up small patterns. The use of inappropriate flooring was evident to a greater or lesser degree in all of the settings. The presence of patterned carpets meant that people with dementia were at risk of being agitated by the patterns and indeed of falling as they negotiated what they saw as changes in floor level (Judd *et al*., 1998; Kerr, 2007).

Case example: Jimmy

Jimmy was sitting in the lounge waiting to be helped to bed. He had been sitting for some time and was becoming increasingly agitated as staff came in and took other people off to bed, leaving him finally on his own.

Jimmy started to bend over to look at the carpet at his feet. The carpet had a large design of bright, light-coloured circles on a dark background. Jimmy slowly bent over with his hand cupped to try to scoop what, presumably, looked like a circular object off the floor. As he bent he started to topple.

All homes had stairs that some residents had difficulty negotiating. This was either because of their mobility problems or because of the problems associated with three-dimensional perception among people with dementia.

Mirrors and reflective surfaces

Residents complained about people coming into their rooms at night. Some of these complaints might have been related to staff coming into their rooms to check. However, the complaints might also have been associated with residents seeing their own reflections in mirrors (Brawley, 1997; Kerr, 2007). People with dementia believe they are younger than their true age (Kerr, 2007). Seeing themselves in the mirror, particularly at night, can be very upsetting, as the reflection will not look like their

perceived self-image and they will believe this to be an intruder. None of the homes paid attention to the possible impact of mirrors on night-time disturbance.

Hazards

During the observations of the night shifts, it was noted that laundry and other items would be left around corridors. These presented a potential risk to people who got up and walked about unaccompanied during the night, as described in the following case example based on field notes.

Case example: potential hazards

About 2am a lady appeared in the sitting room where I *[researcher]* was sitting. She appeared to be agitated and lost. Staff were not available so I asked her if she wanted to sit for a while. After a brief chat she said she wanted her bedroom but could not find it. I walked with her along the corridor. We came upon a music cassette lying on the floor; I picked it up before she stood on it. Then round the corner a towel was draped over the handrail. The lady was steadying herself on the handrail and, if this towel had not been removed, her hand would have slipped along the rail with the towel. Further round the corner a laundry trolley was blocking her way.

This example illustrates a fundamental lack of attention to the environment and the potential hazards of poor housekeeping. There is now a substantial body of literature on the requirement of environments suitable for people with dementia (Calkins, 1988; Brawley, 1997; Judd *et al.*, 1998; Cantley and Wilson, 2003). It was evident that none of the care homes that took part in this study had used any of the literature to inform the structure, decoration or ambience of the environments in which people were living. Night staff were unaware of most of the issues in relation to the environment and so no attention had been given to making suitable adaptations.

Relations between day and night staff

To varying degrees, there were references to the difficulties that existed between the day and the night staff. These centred on issues of communication, expectations and perception:

> They *[day staff]* like us getting so many people up in the morning. Sometimes they can even ask as many as possible. Four, five, they would tell you from this side, get so many up and that side get so many up. (Night care staff)

> Yeah, it's like we have to help each other out in the sense that they say you have to get a few people up for the day staff, but the day staff … have got more staff than us. So we get people up, which means, if I am to get them up, I finish work at 7.30, right, which means I have to get somebody up before I go home at 7.30. (Night care staff)

There were often problems in ensuring effective communication of information between the two staff groups, usually because of the lack of time and contact. Handover meetings between shifts tended to be attended by a few staff from each shift, generally the trained nurses. Care staff had to wait to receive information after the meetings.

The lack of contact and overlap between staff groups also resulted in misperceptions of what each group did and unrealistic expectations from each group. For example, night staff perceived that day staff thought that the night shift was easy, that more residents should have been up when the day shift started and that more incontinence pads should have been changed. The actual views of day staff were not part of this study. What was clear is that such perceptions can create a 'them and us' divide, which can be resolved through better communication.

Summary

- There was a low level of management involvement and supervision of night staff. This led to staff feeling isolated, unsupported and out of the communication link with the running of the home.

- Managers were not aware of some critical and inappropriate night-time practices.

- There was a high level of routine and often unnecessary checking.

- Inappropriate noise and light levels caused disturbed sleep and agitation among residents.

- Staff had received little or no training on dementia. This resulted in inappropriate and sometimes harmful responses to residents.

- Night-time can be an important time for ensuring residents get good nutrition and hydration if awake.

- Staff had received little if no appropriate training on the management of continence. This resulted in inappropriate responses to residents' night-time incontinence.

- The physical environment was not suitable to meet the needs of people with dementia.

- Relationships between day and night staff were often problematic. These difficulties were centred on issues of communication, expectations and perception.

9 What works? The action research phase

This chapter focuses on the interventions (as listed below) that were put in place to address some of the key issues emerging from an analysis of the first phase of the study. Areas of practice that both required and were amenable to change were identified in consultation with staff and management. The changes were also recognised as being of particular benefit to residents. (Note that the need for changes to the physical environment was discussed with managers, but it was recognised that this could not be addressed within the project.)

The proposed interventions were presented to each home as an action plan. The research team met with the managers and then the staff of each home to negotiate the implementation of interventions and the evaluation of their impact. Some interventions were site specific, others applied to all sites. However, for the purposes of this chapter, the focus will be on the interventions, their implementation and impact, and these will not be related to specific homes.

The interventions that were implemented and the homes in which they were tried are shown in Table 3.

Table 3 The interventions and the homes in which they were tried

Intervention	Homes in which they were tried
Managers to increase or instigate their involvement and presence on the night shift	A, B
The practice of 'checking' to be reviewed	A, B, C
Noise and light levels to be reduced and monitored	A, B
A member of the research team to provide dementia training to all night staff	A, B, C
The provision of training on continence management	A
A night key worker system to be introduced with night care plans	A, B
More structured and inclusive morning handover meetings	A, B, C

Each of these interventions was evaluated using written records kept by staff and managers, observations and field notes made during site visits by the researchers, and interviews with staff and managers at the end of the implementation period.

Increased management involvement

There was a commitment by managers to instigate or increase their involvement with the night shift. For example, one manager went in once a week from around 7pm to midnight or beyond. This had a noticeable effect on staff morale and also on the manager's understanding of what was happening at night. It enabled her to talk to staff about the various issues that the research had highlighted and to implement new practices in relation to checking, noise and light levels, a night-time key worker system and new night care plans.

Initially, there was a sense of unfamiliarity and slight tension caused by the increased presence of the manager: 'felt oddly uncomfortable as this was so obviously "their" shift' (manager's notes). This comment underlines how the night shift can become a closed, self-supporting, potentially collusive group with little outside influence. The sense that the night shift runs itself means that the need for supervision and management involvement can appear to be less important than in the day. In this case, the involvement of the manager led to substantial changes in staff morale and practice: 'having [the manager] here has been good. She pops in to see the girls and we are not forgotten' (night staff).

It also enabled the manager to get feedback from the staff. This led to further relatively simple changes within the home, which nevertheless had a beneficial effect on staff anxiety levels. Health and safety procedures were made more accessible and the CCTV camera was moved out of the office into the public space, so all staff could more easily see what was going on outside the home. The reiteration of emergency procedures and the placing of instructions in a more accessible place also had a positive effect. Night staff also felt more relaxed about contacting the manager between visits if they wanted to discuss an issue. This is in direct contrast to the general feeling among night staff that management involvement is mostly the result of something going wrong. One manager stated that the instigation of management involvement at night was a means of meeting staff, giving supervision and getting feedback:

> It's quite good. Rather than coming, as if you're coming sort of heavy handed just to sort out a problem, that we're *[managers]* around for other reasons.

Sometimes, however, a manager was not clear what their role was at night:

> The staff member who was on duty has plenty of experience and I felt she did not think I should be there.

> The staff I worked with *[on the night shift]* have years of experience and I thought it was a waste of time me being there.

This is another instance where the night shift seems to be treated differently from the day shift. There was general agreement that there was no need for managers to be on duty at nights with the same frequency and level as they were during the day, but there was a strong indication that the presence of managers at some stage during the night (initially weekly and then at longer intervals) had a beneficial effect.

Reviewing the practice of 'checking'

The research team worked with managers and staff to establish the reasons for high levels of universal checking and to make everyone aware of the intrusive nature of this practice.

It was important to find a sensible and safe balance between unnecessary intrusion and intervention, and attention to the comfort and safety of the resident. There was an identified need to keep checking at a level that safeguarded residents but that was not determined by staff anxiety. In one home, a night key worker system was introduced so that each resident had a night staff member who was responsible for overseeing his or her care. As part of this function, the worker carried out an assessment of each resident's needs in relation to incontinence, falls, etc. This was then written into an individualised night-time care plan, which informed the frequency and nature of the checks that were made throughout the night.

This change of practice resulted in positive and tangible improvements. Staff now felt happier about their checking routines:

> I would really hate for anybody to come into my room in the morning at 6 o'clock and routinely change me. (Staff)

Interestingly, staff reported feedback from residents that confirmed that the new practice was more person centred:

> Staff 1: And they *[residents]* said they were scared when people were coming in their room through the night.
>
> Interviewer: Have they said that to you?

Staff 2: Oh yes.

Staff 1: They've said that when we asked them. We hadn't really asked them before *[the research]*.

There was also a reported increase in the amount of sleep that residents were getting:

> *[Because]* we don't go into everyone's bedroom now through the night … we found that they do get a better sleep. (Staff)

Residents who had previously woken and then been up and out of bed were now sleeping for much longer periods, some through the entire night (this may also have been a consequence of changes to noise and light levels, as well as the changes to checking routines). Finally, staff also reported that many residents were 'less grumpy' in the mornings, which made morning tasks easier for everyone:

> They're not waking cross in the morning … they're well rested as well. (Staff)

In another home, full hourly checks had been reduced to an hourly breathing check and an incontinence check every four hours as necessary. The anxiety about whether people were breathing had continued and a management decision had maintained the hourly breathing check. While less intrusive than a full pad check, the clicking of the door could still be sufficient to wake light sleepers.

The issue of checking was one that required guidance and intervention from management. Practices had developed in various ways throughout the homes. The frequency and nature of the checking was often a result of staff perceptions of management requirements. The managers themselves were often not aware of the level of checking and their input was critical in changing the routines. Staff had previously felt unable to voice their views, especially where they thought these were not in line with those of management. Lack of management involvement made this misunderstanding, where it did exist, both more likely to develop and more likely to become entrenched.

The reduction and monitoring of noise and light levels

Environmental factors such as noise and light levels were identified as significant contributors to night-time sleep disturbance and were included as part of the action plans.

Noise levels

There were significant reductions in noise levels as a result of the issue being addressed with the staff during feedback discussions and also during staff training sessions. Staff had not realised how loudly they were talking until the researchers pointed this out to them. This noise was reduced simply by increasing staff awareness and their ability to self-monitor:

> Discussion and self-correction about noise … has been taking place. (Notes in manager's diary sheet)

> Oh yes, we have been trying our best *[to be quieter]*. Because before we never really thought about it. (Night staff)

> You do get louder *[as the night goes on]*. (Night staff)

Buzzers and resident alarm call systems were identified as a significant and enduring source of night-time disturbance. The introduction in one home of quieter buzzers at night was an attempt to deal with this problem:

> Well *[the manager]* noticed the noise of the alarms through the night and he got the special night switch fitted in to silence the alarms a bit more. (Night staff)

Staff did identify, however, distinct drawbacks to the use of the quieter buzzers:

> I was in the toilet and I did not hear the alarm … and it had been going for some time … and, if you are in the laundry, it's quite difficult *[to hear the alarm]*. (Night staff)

It transpired that, in this particular home, there were pagers that staff could have used but the batteries had run down and the use of the pagers had lapsed with the introduction of a 'new system' of buzzers. The change from pagers to buzzers had

been because 'They [managers] don't think we really need them' (night staff). Until the intervention by the research team, the night staff themselves had not recognised the need to find a quieter system of alarm. The staff now suggested that pagers should be used routinely at night. This had not been implemented, however, before the conclusion of the study.

The noise made by doors was addressed. The amount of opening and closing of doors was reduced by the decrease in checking. There was also an attempt to make sure that doors were opened and closed as quietly as possible. In one home, the handyman was asked to repair and oil the noisiest doors, and to sort out those that could not be closed properly because of new carpets. The realisation that walking along corridors with creaking floorboards was disturbing to residents did lead some staff to minimise the amount of times they walked along corridors. They were conscious, when they did walk along them, of trying to reduce the creaking by walking more softly and avoiding the creakiest boards.

Other changes were also put in place. Staff tried to avoid wearing bunches of keys that jangled as they walked down the corridors (not an obvious cause of noise, but another unnecessary sound). They were more cautious about the use of toilets and washing machines. To an extent, the issues with plumbing and floorboards are issues related to building design and maintenance, which should be dealt with beyond the direct care staff group.

The implementation of all the strategies listed above led to a noticeable change in the noise levels that were commented on by both staff and management. At times, these resulted in fewer people being up during the night:

> The home *[at night]* is generally quieter. (Manager)
>
> I found that, by keeping noise levels down, that certain residents stayed in their room and seemed to get a better sleep. (Night staff diary)

Light levels

Light levels as an aid or hindrance to sleep are a 24-hour issue. The lack of exposure to sufficient light during the daytime can have a significant impact on sleep among older people (Ancoli-Israel, 2006). For the purposes of this study, however, it was night-time light levels that were addressed.

The importance of light as a source of information about the time of day and night, as an indicator of the tasks that need to be achieved and as a source of agitation and sleep disturbance was highlighted. Staff recognised the need to turn the main lights down so that there was a message given about the time of night. This low-level light was more indicative of night-time and not of the morning when people might think it was time to get up. The dim lights also provided a calming environment, which was more conducive to sleep:

> Yes, there have been other changes *[since the implementation of the action plans]* … like, mostly, we never used to switch off the lights to leave the dim lights during the night but, of late, we make sure that we put most of the lights off and then leave the dim lights for them during the night. (Night staff)

Attention was also given to the light levels when checking or entering a resident's room and the use of torches was introduced:

> Instead of turning bright lights on, we now use torches – less startling for residents. (Night staff diary)

Torches had already been provided in one home but they had not been used, as the batteries were flat. The manager in this home was unaware of the changes that had taken place. Throughout the action phase torches were reintroduced:

> They are a little crystal light just like the ones in your key ring for your car. (Night staff)

The staff used this light to find their way to the bed and then, if necessary, they turned on the night light in the room. This was a plug-in type light that gave a low-level light, sufficient for staff to perform any necessary pad changes. There is a dilemma, however, in the reduction of lighting. It is important that the lighting does not startle or confuse people, but it is equally important that people have clear lighted paths along corridors and in toilets. None of the homes that took part in this study had movement-sensitive lighting systems that would have allowed for dimmed lights until someone moved and needed clear light to show them the way.

The reductions in noise and light levels were introduced simultaneously. Staff described a consequent improvement in resident agitation and waking levels, which they clearly attributed to the changes. They had become self-aware and were able to monitor their own behaviour and even comment on the behaviour of others. In one setting, the staff reminded the manager that she was talking too loudly.

The provision of dementia training to all night staff

The provision of some training was written into all the action plans. This was recognised by all managers and staff as a critical issue and one that needed to be addressed to underpin all the other changes to practice that were anticipated. The provision of training varied slightly across the homes. In two homes it was of one day's duration. The staff who attended this training were not expected to work the night prior to the training, though some did have to go on to do a night shift after a three-hour break. In another home, two one-and-a-half-hour sessions were run in the home on consecutive weeks at changeover time between day and night staff.

The training was provided by one of the researchers who is an experienced specialist dementia trainer. It was person centred and practice based. The staff found the training interesting and seemed to have no difficulty concentrating on the content:

> Well, I found it really interesting. She had us really concentrating … it was that interesting that we don't know where the time went. She had us taken right in. In fact, it was one of the best courses I've been to. (Night staff)

The training proved to be immensely successful in changing staff understanding of both the condition and the experience of the person with dementia. This led to changes in attitude and practice, which were reported in written and verbal feedback by many staff. They provided many examples of the ways in which their practice had changed as a result of the training.

- An increased awareness of how the environment can be stressful and an appreciation of the staff role in this:

  > It was really quite good explaining even about the music, how it can actually agitate people … and the light, even just the light. And how somebody that, if they're having to listen to music and the television and you come along and you're de de de de de, it must be confusing for them, which is probably why they get agitated and it's probably not music they like either, because it wasn't soothing music it was like rock and roll and it's probably the staff member that put it on. (Night staff)

- The recognition that it is important not to collude with distressing memories that will cause the person with dementia to become stuck in their fear and distress, but to use distraction when appropriate:

> And we've got another resident that thinks she's pregnant … She didn't want to be pregnant, she had a really traumatic time. And everybody was just sort of agreeing with her and when we were at the course she *[the trainer*] said to try something different with her, distract her, put her coat on and see if she wants to go for a walk and take her totally off the track. So, rather than agreeing with her all the time, because she said it's not always the best way to go, especially about something like that. So they have tried it and they take her round the block and when she comes back she's forgot about it. (Night staff)

> We have changed what we say when people ask for their mothers. We don't now try to get them round to realise their mother is dead. We learned to talk to them about their mother and then try to get them onto something else. (Night staff)

- The recognition of the importance of colour, particularly colour contrast, and of using memorabilia from the past. In the following case example, it was pictures and music that were used to stimulate and calm the person with dementia. Staff combined these two pieces of knowledge in a very sensitive way that brought positive gains for the person with dementia and also for her husband.

Case example: Eva

Eva, a Hungarian woman, had returned in her dementia to the years before she came to Britain and got married. She was now, in her mind, a 15-year-old girl who spoke only Hungarian. Eva would lie in her bed speaking Hungarian, but not being understood by her husband. Communication was difficult and Eva was doleful much of the time.

Staff suggested the placement of a large red cloth over the wall at the side of the bed. On this cloth Eva's husband placed photographs. Staff described how Eva became increasingly animated and responsive and would point to the photographs and laugh. Her husband changed the photographs every week.

The increased responsiveness also extended to an improvement in her eating. One night she quite uncharacteristically took a biscuit out of her husband's hand and ate it. Previously, any eating had been problematic and was certainly not instigated by Eva. Staff described how she was: 'Eating the jammy dodger *[the biscuit]* and pointing to the pictures'.

The staff also started to play Hungarian music for periods of up to 20 minutes. They found that this was a calming and enjoyable activity for Eva.

- The importance of supporting the person's reality and entering their world (validation) rather than telling them the truth and demanding that they enter the staff's reality (reality orientation) when this would cause them distress (Feil, 1992; Kerr, 2007).

- The realisation that, just because someone has dementia, does not mean they are not trying to communicate and that what might sound like rambling might have meaning if only the person without dementia would listen. The need to stop, listen and try to see the world from the perspective of the person with dementia is illustrated well in the following example:

  > We have a resident who has got Parkinson's. And we're taking more time to listen to him. And he actually is quite coherent, the things that he says … It's unbelievable … It wasn't until someone points it out … It's amazing what he comes out with. (Night staff)

  > See, since this listening to them, it's made a big difference. He *[resident]* said this morning, when I got him up, he said, 'Do you know there was people coming in here and moving all my furniture about?'. I says, 'During the night?'. He went, 'No', he says, 'in the morning. She had this great big thing.' And I says, 'Oh, was it the domestics?'. He says 'Yes'. It was because I was actually listening to what he was saying now … it could have sounded like he was talking rubbish. Well, before, we would have thought that, now we think. (Night staff)

- The recognition that staff themselves, by the use of incorrect responses and reactions, could be inducing problematic and avoidable behaviour:

  > Since the training on dementia there has been a definite reduction in instances of challenging behaviour and accidents at night. (Manager)

- The recognition of the way in which diagnostic overshadowing, such as attribution of behaviours to the dementia rather than to pain, can result in people with dementia not being given adequate pain relief, particularly at night:

  > I am much more clear about dementia and what experience the person with dementia has. I did not realise that sometimes her *[resident]* behaviour was because she was in pain. We didn't seem to realise that. So, once they gave her something for the pain, and we have to give it to her at night now regular every night, paracetamol, and she is much better. And she is better in the daytime as well. I think *[this is because]* she is getting a better rest. (Night nurse)

> Another one is G *[patient's name]*. I find that when I give her pain relief she is better through the night. With G, I give *[paracetamol]* to her. She is written up *[since the training]*. She gets better sleep now. (Night nurse)

These are just a few of the many examples that were given of simple but significant changes following one day's training. The impact of the changes on the quality of care for individuals illustrates the necessity for regular and effective training on the basic tenets of dementia care. It is also critical that training is up-to-date and high quality. When it is for night staff, it must focus on their needs and address night-time care issues.

Timing is also important. The provision of daytime training that night staff attend after a night shift makes unrealistic and unfair demands on staff. The training must be either at night or on a day when night staff have been released from the night shift both before and after training. Staff must be paid for their time.

The maintenance of continence and the management of incontinence

A lack of adequate training on the maintenance of continence and the management of incontinence was identified. The consequent anxiety and sometimes inappropriate practice meant that it was part of the action plans of all homes.

Only one home was able to provide any training to the night staff during the duration of this study. A specialist nurse delivered the training at 9.30pm to allow night staff to attend. While staff found this helpful in many ways, they had some important reservations. The training had been the same as that provided for day staff and some of this was inappropriate because of the different incontinence needs of residents at night. For example, the difficulty of managing people who are not standing and the need to turn residents in bed and to have limited help for what was seen as heavier work were highlighted:

> That was fine *[the training]*, but it's *[night-time]* different altogether. Well, people are simply tired. You're rolling them in their bed. You know, people aren't standing up, waiting for us to put their pads on. They can get quite annoyed at night. (Staff)

> The really bad time and busy time is the morning from 6 to half past 7. So it can really be quite chaotic. You're changing their pads on your own because you've got plenty to do – because there's a lot to do in a short time, there's people to get up. (Staff)

The provision of adequate and suitable pads was raised as a problem across the homes, especially as the pads were usually ordered by the day staff. This meant that often the pads were not suitable for night-time needs. A person who can maintain continence during the day might require a pad that will support a high level of urine through the night, and day staff might not anticipate this and order stronger pads.

The need for continence to be a 24-hour programme and not just a daytime issue was highlighted. This practice was changed by improving communication over the issue between day and night staff, which resulted in an improvement in the pads provided.

How people were washed and changed was also an issue, especially the way in which staff approached people. By gently waking the person, with the use of a low light and a calm, gentle voice and as little intrusion as possible, the disruption to sleep was hopefully minimised. One home introduced the use of foam as a cleaner, as they thought that this was more gentle. It also meant that they did not have to keep running the taps, which caused loud noises to be emitted from the old plumbing. It was not possible to measure how the use of foam improved the experience of the residents, but it was an illustration of how staff were thinking about how to minimise intrusion and disruption to residents.

The management of continence worked in parallel with the need to reduce the amount of unnecessary checking. The use of a night-time key worker system (see below) and individual night-time care plans meant that individual risk assessments were carried out to reduce the need for checking. It was critical that staff had a better understanding of continence issues and that the correct pads were made available and used.

A night key worker system with night care plans

One home introduced, with management support, a night-time key worker system with linked, more detailed, night-time care plans. This change was implemented through the following process.

- The management developed and provided key worker 'guidelines.'
- Information was elicited from all night staff about the residents with whom they felt most able to work.
- Residents were then allocated to workers, with each worker having, as far as possible, a cross-section of residents.
- Each worker was allocated seven residents.
- The night worker's remit was to develop a specific night-time care plan for their key residents. Night workers were given 'more autonomy and specific input into their key resident' (Manager).
- Part of the care plan was to carry out a risk assessment in relation to incontinence and falls.
- The care plan will inform the level and extent of checks though the night.
- Day and night key workers will meet every two to three months to organise and share care plans across the 24 hours.
- There was an expectation that they would also meet every month at handover meetings.
- The assessment was to be shared with relatives, as far as possible. Because this particular home had relatives' meetings in the early evening, it was possible for night staff to meet relatives at the beginning of the night shift. Where this was not possible, the night-time care plan was to be given to the linked daytime key worker for the particular resident, so they could share it with relatives.

This system was implemented and ran for a period of four months before the action research part of the study was terminated. Even within this short time-frame, there were clear signs that this new system had led to benefits for residents:

> The night care plans have nudged us all to think again about individual residents and having them *[care plans]* together in a 'night folder' will make them more instantly accessible and be particularly useful to new staff. (Night nurse diary)

> I am sure a lot will be achieved, there is a continuation from day to night staff. (Night staff diary)

The following comment is critical:

> The challenge will be to make sure that they *[the care plans]* are used and reviewed regularly. (Night nurse diary)

This would be one of the tasks that the manager, in the role of night-time supervisor and manager, would pay attention to.

However, some staff did not consider that the introduction of the key worker system at night had changed their practice:

> It's not altered our shift; it's not altered the way we go about our business. When you work at nights … there's not much sort of input, it's maybe more through the day. (Night care staff)

> We're so close at night with them, we know them already. I think it is different during the day, because they see their needs, like needing the toilet and they can do one to one with the relatives … we don't see the relatives. (Night care staff)

The system that was introduced brought benefits even in the short term to most staff and residents, and led to 'more complete social care' (night care staff). There were some staff with reservations, but this may have been linked to insufficient explanation about the new system.

The development of handover meetings between day and night staff

In two of the homes, new handover arrangements that included more night staff were instigated to improve communication and relationships between day and night staff. This change in the content and format of the handover meeting was generally seen as an improvement:

> It's *[the inclusion of all staff in the handover meeting]* made a difference because you're sitting with the day shift, whereas before we were giving a handover to the manager ... and we weren't getting anything back. (Night care staff)

> Change to handover was excellent. I enjoy it. Talking to other staff and the communication is excellent. Also good to meet officers *[managers]* at handover, good to feel part of a team and not isolated, as this can be sometimes what nightshift feels. (Night care staff diary)

> It definitely is positive ... we now find that something gets done when we mention it. (Night care staff)

It may well have been the case that things did get done before the change in handovers, but now the staff know and recognise that their information has been acted upon.

There were, however, some teething problems with the changes, especially as the number of night staff members attending the handover had a potentially negative effect on the residents:

> Because you are in a hurry to get down for the report, you hurry them *[the residents]*. We don't seem to have time because we think 'oh we need to get down there and write all this up'. (Night care staff)

Clearly, there were many advantages to the more inclusive handover meetings, but consideration has to be given to staff cover and the impact on residents, particularly as this is a busy time when residents need much attention. This problem might be alleviated by the suggestion that extra staff could be employed on a short shift during the period before and after the morning handover.

Summary

- The changes were presented to each home as part of an action plan; some were site specific, others applied to all sites.

- The impact of the interventions was assessed through interviews with staff and managers, and through observations of night shifts and from staff and managers' diaries kept over the period.

- Findings indicated significant changes to staff care practices. It needs to be noted that these are the optimum findings and changes. Not all homes achieved all the changes and one achieved very little.

- The increased involvement of managers led in the most receptive home to a lessened sense of isolation among night-time staff. It also increased communication between staff and management. Managers had a better idea about night-time practices and were able to influence the changes implemented.

- The practice of checking was changed from a routine indiscriminate activity to one based on individual risk assessments. This resulted in less sleep disturbance among residents and a reduction in unnecessary intrusion.

- Noise and light levels were reduced. This led to less disturbed sleep among residents.

- The provision of specific, practice-based, person-centred training on dementia resulted in significant changes in staff understanding of people with dementia and a consequent positive change in practice.

- The provision of training on maintaining continence and managing incontinence was helpful but would have benefited from a focus on night-time specific issues.

- A night key worker system and an enhanced night-time care plan facilitated more individualised responses to residents, particularly in relation to the management of incontinence.

- More structured and inclusive morning handover meetings improved relationships between day and night staff, and led to better communication of residents' needs.

10 Key messages and recommendations

While sleep is an obvious objective of good care at night, this can also be a time when a range of beneficial and effective care practices can be carried out. This study sought to identify ways to improve the quality of night-time care and has highlighted an area that is extremely under-researched and undervalued.

The study found that night-time care was viewed through a lens of anxiety and limited knowledge. When discussing night-time, the care staff, inspectors and relatives all expressed high levels of anxiety. This related to the lack of knowledge from all groups about what happened at night and resulted in worries about 'what if' situations. In practice, this anxiety – exacerbated by poor communication and low levels of staff training and staffing – resulted in poor night-time care practices. Staff struggled to provide good levels of care in environments that were inappropriate, following structures and 'rules' that were often ill informed and based on perception rather than clear guidance. Night staff were notably less well trained, supported and supervised than day staff, yet they were working with high levels of responsibility and accountability, and were providing often complex levels of care.

Based on interviews with regulators, staff, relatives and residents, and on observations and field notes, the study identified, implemented and evaluated a series of practices that required change. These changes were not implemented uniformly throughout all the homes, and, where they were achieved, this was over a short period of four months. The changes achieved were largely a reflection of management commitment, staff willingness and better understanding and communication of what was required.

This action research has identified a number of key strategies that could alleviate and address these practices and areas of concern. Many of these are relatively easy to implement and cost little or nothing. They include the following.

- *Regular management involvement:* this increases management understanding and knowledge of what is happening in practice during the night and enables clear guidance on key practices such as checking, continence care, noise levels and staff supervision.

- *A strong emphasis on individual care:* night-time key workers and care plan systems allow for individual assessments and person-centred care.

- *Reduced dependence on agency and bank staff:* this minimises the workload of regular night staff and improves quality of care.

- *Dementia-focused and night-time appropriate training* for all night staff, at times that are convenient: in addition to general provision on working with people with dementia, there are specific areas on which to focus, such as continence management, pain management and the impact of the environment. Each of these areas should be appropriate to night-time care and, where possible, be delivered by experts such as continence nurses.

- *Control of noise and light levels, and other environmental variables:* staff should reduce voice levels, use pagers not loud buzzers for alarm systems, dim lights in communal spaces before bedtime and arrange maintenance work to reduce noisy floorboards, plumbing and doors.

- *Clear communication is central to all the work:* all staff should be able to communicate clearly and appropriately with residents. Morning handover meetings should be more structured and inclusive. The provision of an additional staff member would improve the morning period between 6am and 9am, and would allow more night staff to attend the handover meeting.

Such strategies result not only in a general improvement in care standards for residents but also in increased staff confidence and reduced feelings of isolation and vulnerability.

Final comment

As the proportion of people with dementia living in care homes increases, there is an imperative to provide improved care that is based on an informed understanding of the needs of both residents and staff, during the night as well as the day. A poll in 2007 highlighted that 66 per cent of adults are frightened by the prospect of going into a care home, 55 per cent of adults across Britain do not believe older people in Britain are generally treated with respect and 40 per cent fear being lonely in old age (*Guardian*, 2007). These patterns of ageing, care and feelings about growing older affect us all.

For more fundamental and long-lasting change to be achieved throughout all homes, there is a need for more rigorous, policy-driven interventions and guidance. At the end of 2007, as governments across the UK develop a range of national strategies to improve dementia care (www.dh.gov.uk 2007; Scottish Government, 2007) and campaigns focus on dignity of older people using hospitals, care homes and home care services (Healthcare Commission, 2007), it is timely to ensure that night-time care is addressed within these moves.

Within such policy developments, care standards, which focus largely on daytime issues, need to be better targeted and to be backed up with more rigorous implementation by the responsible inspection bodies. A tendency for policy, evaluation, training and inspections of care homes to focus on day care to the detriment of night-time care was evidenced throughout this study. The assumption that general policies will cover night-time issues is clearly erroneous. Specific emphasis on night-time provision must be given in all areas of training, inspection and policy if we are to ensure an effective and appropriate 24-hour service.

Recommendations

Context

Each recommendation is made in recognition of night-time care being a key element of the provision of a 24-hour care service. The recommendations are based on the principle that care at night is not only about promoting good sleep. This can also be a time when positive care practices can be carried out and when a resident awake during the night can engage in other beneficial activities.

Recommendations for UK regulatory bodies

- Include night-time inspections as standard, not just as a response to complaints.
- Ensure that inspectors employed are aware of the terms and conditions relating to contracts, where contracts allow for working out-of-hours periods.
- Ensure that inspectors have specific awareness and training on dementia and night-time issues.
- Ask inspectors to ensure that staffing schedules focus on meeting the care needs of residents 24 hours per day.
- Check that training modules for all staff reflect night-specific issues.
- Check that care home managers and staff understand that the minimum qualification requirements apply equally to night and day staff. The qualification requirements set out in the National Care Standards apply to all staff in care homes regardless of whether they work during the day, night or weekends.

- Ensure that relatives are given adequate information about night-time staff and practices.

Recommendations for home management

- Implement regular communication and support strategies between the manager and night-time care staff.

- Ensure that environmental concerns within the care home setting are addressed and, where appropriate, relevant technology is used, e.g. guidance around noise, light, safety, silent call system.

- Ensure that systems are in place for night staff to have all the equipment, technology and facilities required to provide good night-time care.

- Monitor staff training requirements and ensure appropriate times/conditions for such training to be provided effectively.

- Keep the use of agency and bank staff to a minimum – where possible, use staff who are familiar with the care setting and the residents.

Recommendations for management with night staff

- Implement a system of regular communication with, and supervision of, night staff.

- Give clear messages and specific guidance about the expected night-time practices.

- When overseas staff are employed, ensure they are supported to speak English at a level comprehensible to the residents and other staff as a basic requirement. Provide basic training where possible, especially where there are difficulties in recruiting night staff.

- Develop and provide guidance to night staff on the impact of night working on their well-being, and offer strategies to support better health – to include information on nutrition, etc.

- Consider adopting a full rota system, which means there are no night and day staff.

Recommendations for care home with relatives

- Provide relatives with an information sheet about basic expectation relating to night-time care.
- Include up-to-date photographs of night staff as part of the information.
- Inform relatives of the resident's night-time key worker and encourage some form of regular communication between them.
- Have regular meetings for relatives to improve communication and information sharing.

Recommendations for care home with residents

- Ensure that each resident has a night-time key worker, who will take responsibility for: producing and reviewing the night-time care plans; communicating the resident's needs and any changes to other staff; providing a communication link between the resident and their relatives.
- Use night-time care plans to regularly assess and communicate the needs of the resident through the night. Information should include regular professional assessments of continence support and pain needs.
- Use practices such as checking and changing pads with minimal disruption, ensuring the way the way they are done is individual, gender-appropriate and sensitive to communication needs.

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