QUALITY IMPROVEMENT

Culture change in care homes: a literature review


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None declared

Abstract
This article is the first of a two-part series that explores a programme of culture change in care homes. A UK care home company sought the authors’ expertise to design and facilitate an independent programme of learning to encourage and support staff in two of its homes to become the architects of their own quality improvement.

The article reviews the literature that was an essential information base for the authors in their dual roles as designers of the learning programme and facilitators of its delivery to participant staff. The literature is necessarily broad in reflecting the nature and context of care homes, residents’ needs and wants from care, and the particular challenges that might be faced by care home staff and managers when making quality improvements. In the second article, the reality of running the programme in the two homes is described.

Keywords
care homes, culture change, long-term settings, older people, quality improvement

IN THE UK, there are an estimated 5,153 nursing homes and 12,525 residential homes, which cater for 426,000 older and disabled people, approximately 405,000 of whom are aged 65 and older (Laing and Buisson 2014, Age UK 2016). An estimated 1.46 million people are directly employed in adult social care in the UK, approximately half of whom work with older people; by 2025 the number required is predicted to increase by up to 65% (Skills for Care 2015). In 2014, the basic wage for 78% of social care assistants was £6.45 an hour (Kennedy 2014), placing them among the lowest paid UK workers.

As of 1 April 2016, the national living wage for those aged 25 and over is £7.20 per hour and will be subject to annual revision. The national minimum wage per hour continues to be applied to those aged 24 years and under, ranging from £3.87 (under 18 years) to £6.70 (between 21-24 years), excluding apprentices who are paid at £3.30 (UK Government 2016). Care homes’ services are complicated by a two-tier provision in the UK. Six out of ten older people living in care occupy beds in residential homes staffed solely by social care assistants with low-level healthcare skills training. This means that only four out of ten older people live in homes with nursing care (Szczepura 2011). Irrespective of being registered as ‘with’ or ‘without’ nursing, and despite reported overlap in the care requirements of older people in residential homes with those in nursing homes (Lievesley et al 2011), each type of home is given the generic title ‘care home’.

The appropriate level and skill mix of care home staff can be difficult to establish in long-term settings, where residents’ needs are complex and staff recruitment and retention are challenging (Hodgkinson et al 2011).

To address these difficulties, policies in England (Department of Health (DH) 2010, 2011) and in Scotland (Scottish Government 2012) have sought to stimulate the growth of new models of care. The need for continuous learning in social services care homes has been an ongoing focus (Skills for Care 2011).

In an English model of teaching fundamental nursing skills to social care staff in residential homes with in-house support from a dedicated nursing team, outcomes included a cost-effective reduction in hospital admissions and community nursing input to the homes (Szczepura et al 2008a); the enhanced care was popular with residents. However, despite the increased skills provision, these residential homes were not eligible for funded nursing care unlike those in Scotland.

When the costs of care for illness-related...
dependency escalated beyond the level of fees, residents were likely to be transferred to a nursing home rather than have the ‘home for life’ that they and their relatives wanted (Wild et al 2010).

Residents’ met and unmet needs
Older people enter care homes because they can no longer manage to live at home, even with regular community care input. Reasons for care home admission are predominantly because of compromised mental or physical health and/or increased burden on carers (Buhr et al 2006, Centre for Policy on Ageing (CPA) 2012).

The disabilities of later life rarely exist in isolation, and multimorbidity increases the likelihood of dependency (British Geriatrics Society (BGS) 2015). In a census undertaken by a major independent care provider, three quarters of residents required the assistance of, or were dependent on, care staff for their mobility; only 28% were continent, 64% were confused or forgetful, and 46% already had a diagnosis of dementia (CPA 2012).

In 2001, the National Service Framework for Older People (DH 2001) pledged major improvements for older people including a commitment to access to NHS care irrespective of their location. However, the provision of NHS services to care homes has been described as ‘patchy’ and the social care model dominant in homes without nursing, is insufficient to meet older people’s needs (BGS 2011).

It appears that since the millennium, despite policy, there has been little widespread change in older people’s access to NHS care, especially if they are living in care homes without nursing care. In other related evidence, maintaining function and providing continuing care or palliative care are important to health and well-being, as life expectancy for older people after care home admission is around 15 months (Forder and Fernández 2011). However, Crocker et al (2013), in a systematic review of 67 multinational trials with older people living in long-term care facilities, found that although physical rehabilitation may be effective in reducing disability, there was insufficient evidence to ascertain its sustainability or cost effectiveness.

Assessing the standards of care in care homes presents mixed evidence. Eliopoulos (2010) purported that as media attention is focused on reporting instances of poor care, the achievement of high quality care in residential and nursing homes may be under-acknowledged, that is, good care homes do not make news. An Age UK (2013) report stated that, although beset by bad publicity, many care homes are working well to provide ‘good quality of care’ for residents and, in dementia, major innovation is taking place (Scottish Government 2011, Dementia Partnerships 2012). However, the Care Quality Commission (CQC) (2015) in England rated 36% of residential homes and 55% of nursing homes as inadequate or requiring improvement.

Lack of staff, poor safeguarding and poor medication management were important areas where improvement was required (CQC 2013). As a guide to the provision of good care, the CQC (2015) identified the main features of homes receiving good ratings as those:

- Operating with transparency.
- Having good governance processes to support leadership at all levels.
- Using audit tools and having mechanisms to report mistakes and inaccurate care documentation.
- Having appropriate skill mix to meet the needs of their particular residents.
- Having less reliance on external agency staff.

The Royal College of Nursing (2012) called for better working conditions for care home staff and greater appreciation of the good work being done by many despite feeling demoralised and undervalued at times.

To enhance the quality of care, acquisition of digital skills is recommended to enable greater access to e-learning, care planning and record-keeping (Dunn and Braddell 2014), which was confirmed in a project undertaken by Wild and Kydd (2016). In-house care home staff took on the role of volunteer champions providing digital skills training for other staff (Wild and Kydd 2016).

What do older people want from care?
Care homes exist to provide care for people who can no longer remain in their own homes usually because of a complex combination of physical, mental, psychological and social impairments and losses. Kydd (2009) identified seven attributes that older people want from nurses as caregivers (Box 1).

Older people also want their caregivers to be ethical practitioners who uphold individuals’ human rights (Age UK 2011). Wild et al (2012) suggested that in caring for and about older people with multiple needs, providing remedial (to make better) care offers huge opportunities for staff to be proactive in gaining and using expert knowledge of assessment, care planning and understanding of the uniqueness of residents as individuals.

Where there is loss of physical and mental

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**KEY POINTS**

5,153

Number of nursing homes in the UK

12,525

Number of residential homes in the UK

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function in later life, older people’s ability to exercise autonomy over care becomes more difficult. Many staff will rise to the challenge, providing specialist, person-centred care (Touhy 2016). However, other staff may infantilise residents, possibly reverting to this inappropriate relationship-type because it is one that they are familiar with (Marson and Powell 2014). A study by Beel-Bates et al (2007) found that care home residents often comply with such behaviour by staff with deference. This illustrates the powerlessness of residents but also presents the possibility that staff may interpret residents’ behaviour as acceptance. This demeaning form of care relationship should be challenged before it becomes embedded as accepted cultural ‘norm’.

One view of the status that could be afforded to care home residents is to liken the weekly fee paid to the cost of a foreign holiday in a superior hotel inclusive of flight. Similar to tourists, care home residents should be perceived as consumers entitled to as good a service as their level of fees provides. In keeping with this consumer-led premise, Burger et al (2009) suggested that the defining standard for good care practice should go beyond resident-centred care to resident-directed care. However, unlike holidaymakers, if the voices of care home residents are unable to be articulated through illness or disability, they could become hostage to their own, relatives’ or the public’s funding fortunes. They are unable to go back to their own homes and locked physically and psychologically in an unfamiliar environment in which there is no obvious way of turning the clock back. In their qualitative study in care homes, Bowers et al (2009) found that many residents lacked control over day-to-day decisions and those that were life-changing such as moving into long-term care. Professionals may place too much emphasis on risk to older people and not enough on their autonomy (Joseph Rowntree Foundation 2012).

**Changing care home culture**

Organisational culture is an important feature in the quality of care provided in care homes, but it is ill-defined (Spilsbury et al 2015). The following definition of culture provides a ‘best fit’ in the context of care homes where diversity in quality of care is apparent (Oxford Dictionaries 2016): ‘The beliefs and attitudes about something that people in a particular group or organization share.’

Conclusions from a thematic literature review of care given by staff in care homes highlighted limited subscription to evidence-based practice, the need for further development of home managers as change agents, and the importance of investment in staff development as a precursor to changing a task-orientated care culture (Szczepura et al 2008b). Manthey (2002) suggested that changing practice alone will not change culture if innovation is not encouraged and would-be innovators feel disempowered.

Other authors contend that changing practice requires a clear remit, including a justification and a shared philosophy of care with the home manager leading by example to enable staff to take on new ways of working (Patterson et al 2011). These attributes were echoed in a US model enabling cultural change in a primary care nursing setting, where an inspirational and credible leader was one who communicated with staff, listened to the story of change as it unfolded, and recognised new opportunity (Jost and Rich 2010). Scalzi et al (2006) found that the exclusion of registered nurses from top-down decision making was the greatest barrier to implementing culture change in US nursing homes.

Significant culture change has to start with the home’s owners and administrators (Szczepura 2011). Senior managers, often located in a head office far from the home, should focus on building relationships with all interested parties (Deutschman 2005), invest in staff training and establish a more participatory decision-making style, especially with the home manager (Orellana 2014).

**An approach to support programme facilitation**

The literature review was an essential information base for the authors in their dual roles as designers of the learning programme and facilitators of its delivery to participant staff. In anticipation of their facilitation role, the authors recognised their own need for a philosophical approach that would promote staff’s learning journey as positive, enjoyable and autonomous. Appreciative inquiry (AI)
was the approach most suited. It first emerged in the 1980s through influential writers such as Cooperrider and Srivastva (1987) and was further interpreted by Bushe (2011) who described four principles for AI (Box 2). However, Bushe (2010) cautioned that AI can focus too much on what is positive and not enough on the transformation that it can influence. From his research, he observed that transformational change was through the creation of new ideas. This gave people new ways to address old problems. For this to occur, he suggested that AI must address problems by creating images of the best solutions that can be envisaged. The benefit of this approach when applied will be addressed in part 2 of this article.

**Conclusion**

The literature review provided the authors with a breadth and depth of insight into the relatively closed world of care homes, in comparison to the more open public healthcare systems, where arguably improvement through research and policy appears to be slow to take effect. The nature of the care provided seems to be influenced by:

- The diversity of residents’ health characteristics.
- The opportunities available to staff to gain knowledge and awareness of alternatives to their current practices.
- The environmental features of the home.

**References**


Senior staff and home managers’ leadership and management skills.
- Supportive supervision.
- Skill mix.
- The parent company’s vision, mission and value-driven willingness to invest in innovation.

The literature further suggests that changing practice alone is unlikely to be sustained if the culture in which it takes place is not similarly addressed. When considering this evidence base as a foundation for the development of a quality improvement learning programme, the authors recognised the opportunity to devise a tailor-made, reflective and flexible programme, grounded in the unique context and circumstances of each home. To be effective and sustainable it would need to move away from the traditional emphasis on ‘learning what is taught’, towards one where ownership of the learning journey to underpin change was placed in the hands of the home’s staff and manager.

In part two of this article, the design of the programme and its facilitation in two care homes in Scotland are explored in more detail. This is supplemented by the challenges and successes when up and running, and what the authors learned from their journey that ran parallel to that of the homes’ staff as participants.

**Implications for practice**
- The difference in residents’ healthcare needs in homes with and without nursing services has narrowed.
- Care home residents are entitled to NHS services but access is inequitable.
- Media reports focus on homes where quality of care is poor, which serves to discount and demoralise those providing high-quality care.
- Diversity in care homes, residents, staff, managers and parent companies is an important factor influencing culture change.

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**Resources for care home staff**
- **My Home Life is a UK-wide initiative that promotes quality of life and delivers positive change in care homes**
  - http://myhomelife.org.uk/resources-and-information
- **Royal College of Nursing care homes advice guide**
  - www.rcn.org.uk/get-help/rcn-advice-care-homes

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www.rcn.org.uk/actoin-areas/reshaping-care-for-older-people (Last accessed: 5 July 2016)


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