Practice of Namaste Care for people living with dementia in the UK

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Abstract

Originating in the US, Namaste Care aims to improve quality of life for people with advanced dementia. However, recognition in the UK is sparse. This article reports on research that aims to create consistent understanding of the purpose, application and effect of Namaste Care. Using an online survey, telephone interviews and discussion group with UK practitioners we explored Namaste Care practice, its components and implementation challenges. Findings show that Namaste Care has potential to improve quality of life in advanced dementia and is held in high regard by practitioners. However, understanding is inconsistent and practical implementation highly varied.

Author details


Keywords

dementia, end of life care, older people

CARE HOMES can struggle to meet the needs of their most dependent residents. Untreated or undertreated pain is commonplace (Corbett et al 2012), leading to distress, disturbed behaviour, depression, decreased functioning and increased dependency (Care Quality Commission (CQC) 2015). People with advanced dementia often become isolated, which compounds negative health outcomes. Care staff often struggle to find appropriate interventions to engage people at these later stages of the condition.

Namaste Care is a multicomponent approach that aims to enhance quality of life for those with advanced dementia through a combination of physical, sensory and emotional interventions. ‘Namaste’ is a Hindu greeting meaning ‘to honour the spirit within’. The approach was developed by US practitioner Joyce Simard who recommends integrating Namaste Care into a daily regimen with sessions delivered twice a day, morning and afternoon, by care workers who are allocated the role of Namaste Care practitioners (Simard 2013). A manual and toolkit have been developed to support Namaste Care practitioners and training workshops have been delivered in the UK since 2012 (Stacpoole et al 2015). The manual recommends that Namaste Care sessions take place in a specially prepared room or area with low lighting, soft music and comfortable seating. Each resident is warmly welcomed. Residents are assessed for pain and offered frequent hydration and preferred foods during the session, to meet need but also stimulate senses. Tactile interventions and ‘loving touch’ form an integral part of the approach and may include hand massage, foot spa and hair brushing. Music, singing, dolls, pets and nature are used in the sessions according to individual preference and need.

A research evidence base for Namaste Care is beginning to emerge. A US study across six centres with 86 people with advanced dementia found that five-hour daily Namaste practice resulted in a significant decrease in withdrawal and agitation, a reduction in delirium indicators and anxiolytic medication (Simard and Volicer 2010). A UK action research study in five nursing homes showed significantly reduced behavioural symptoms and occupational disruptiveness in four of the participating homes (Thompsell et al 2014, Stacpoole et al 2015). A further UK nine-month pre–post study in three care homes found reduction in behaviours that challenge and depression for
ten out of 14 participants (Soliman and Hirst 2015). Namaste Care implementation has also been associated with a significant reduction in antipsychotics and hypnotics for nine residents of a Scottish nursing home, alongside a reduction in sleep disturbance and positive family appraisal (Fullarton and Volicer 2013).

An Australian study identified that carers and family members reported improved comfort in their interactions with people living with advanced dementia as a result of Namaste Care (Nicholls et al 2013).

Randomised controlled trial evidence has not been reported but the approach has high face validity across several countries with families and staff. It fits well with expert opinion (van der Steen et al 2014) on what must be delivered to meet the end of life needs of people with advanced dementia. It is a person-centred approach in line with the most recent national guideline for dementia care (National Institute for Health and Care Excellence 2006).

**Aim**

Introducing Namaste Care into regular care home routines is not straightforward. The authors are leading a three-year implementation study funded by the Alzheimer’s Society with the aim of determining an optimal UK intervention based on Namaste Care principles.

A starting point for the research was to learn from the experience of those who had already begun to implement Namaste Care in UK care homes. To date there has been no consistent feedback from practice.

Knowledge gained from this experience, alongside a literature review of the components of Namaste, will shape the proposed Namaste Care Intervention UK to be tested in the implementation research, as well as identifying issues to be investigated further as part of the research.

**Method**

A sequential investigation to engage directly with UK Namaste Care practitioners was undertaken as summarised in Figure 1.

An online survey was developed asking questions about different aspects of Namaste Care and its delivery. The survey was distributed through multiple channels. Initially, 50 individuals and four care providers known to have an interest in Namaste Care were identified through those who had led training courses and workshops in the UK. The survey was also cascaded through the Contact, Help, Advice and Information Network (CHAIN), Alzheimer’s Society, Dementia UK and the study team’s distribution lists, websites and social media. The survey was open for four weeks in late 2016, with reminders sent after two weeks.

Survey respondents who had either practised or observed Namaste Care were invited to participate in an in-depth telephone interview. The interviews aimed to clarify and expand on the survey findings to gain a better insight into the barriers and facilitators experienced when implementing Namaste Care. Topics included the content and frequency of Namaste Care sessions, practicalities, training and support provided and the effect of sessions.

Researchers identified a convenient time for interviews and e-mailed consent forms for completion and return. Three researchers conducted the interviews, which were audio recorded and transcribed. Transcripts were thematically analysed (Ayres 2008, Braun and Clarke 2013, Vaimoradi et al 2013) by two researchers who considered various aspects of Namaste Care practice.

The survey and interview findings were synthesised with those from the literature review to create a draft Namaste Care Intervention UK. This formed the basis of a practitioner consultation event, comprising three structured roundtable discussions between the research team and practitioners who had taken part in earlier activities. As well as refining and verifying the optimal intervention, the discussions aimed to identify important points of development required in the later phases of the study.

**Figure 1.** Overview of activities to explore UK practice of Namaste Care and development of the optimal Namaste Care Intervention UK
Ethical considerations
Approval to conduct the survey and telephone interviews was granted by the University of Worcester’s research ethics committee.

Findings
The online survey was completed by 100 people, with less than half (n=43) having direct experience of Namaste Care (Table 1). Most respondents were interested in the approach but had not directly practised or observed it. Of respondents, 20 directly practised Namaste Care and identified themselves as managers and activity coordinators working in care homes. Only four respondents specified that they had a nursing role, but 13 said they worked in a nursing home, hospice or NHS continuing care unit. Respondents who had observed Namaste Care identified themselves as managers and staff working in care homes, hospices, hospitals and people’s own homes.

Of the 24 volunteers for telephone interviews, 13 took part (Table 2). Six of these interviewees were either working in a nursing role or had a nursing background.

Twelve practitioners took part in the roundtable discussions, including three who had participated in the telephone interviews.

There was significant overlap between the findings and feedback from the survey, interviews and roundtable discussions. These are reported below. Not all survey respondents answered every question, so the number of actual responses is indicated where appropriate.

Set up and preparation
Many of the survey respondents practising Namaste Care were new to the role with nine out of 13 delivering Namaste Care for less than a year. Only three out of 12 respondents reported receiving ongoing professional support, although a further two indicated that they felt support was not necessary.

Training was regarded as highly important before starting delivery of Namaste Care, but experience of this varied among the telephone interviewees. Some practitioners had attended formal training courses, observed Namaste being delivered or read the Namaste Care book (Simard 2013). Others had received no training or did not know it was available.

Responses indicated that in some cases Namaste Care was delivered in ways more akin to an activity session for residents than an embedded part of daily care. This suggested a lack of clarity about what constitutes Namaste Care and what is a Namaste-like activity.

Telephone interviews and roundtable discussions found varied opinions about Namaste Care participants. While some interviewees focused on people with advanced dementia or at end of life, others felt Namaste Care should be delivered to anyone who ‘psychologically needs one-to-one care and attention’ (telephone interviewee (TI) 4) as ‘some of our non-dementia residents have gone in and really enjoyed it’ (TI5).

Delivering Namaste Care
Three out of 12 survey respondents reported that they were the only dedicated Namaste Care worker, which is at odds with the whole team approach advocated by Simard (2013). However, six more reported that they were part of a wider team of staff members involved in delivery of Namaste Care. Interviewees also identified that aspects of the team approach were relevant in terms of successful implementation, with training, dedicated time and strong, enthusiastic management sponsorship being powerful facilitators.

There was agreement among all telephone interviewees, supported by the roundtable discussions, that to be successful Namaste Care must be first implemented by those in leadership and influential positions.

With regards to who should be responsible for delivering Namaste Care, some interviewees thought that all staff should be responsible, whereas others advocated that there should be dedicated roles:

‘One care home actually used everybody […] used all their care staff, which was absolutely fantastic […] they would have a rota and that worked really, really well’ (TI12).

Session locations and group sizes
Survey comments indicated that Namaste Care sessions were held in a variety of spaces: dedicated rooms, communal spaces such as a lounge or occasionally on a one-to-one basis in a resident’s bedroom.

Table 1. Summary of the online survey respondent numbers

<table>
<thead>
<tr>
<th>Response</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Of respondents</td>
</tr>
<tr>
<td>Practising Namaste</td>
<td>20</td>
</tr>
<tr>
<td>Seen Namaste in practice</td>
<td>23</td>
</tr>
<tr>
<td>Heard of Namaste but not seen practised</td>
<td>57</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>
Roundtable discussions highlighted that practicalities in a care home may dictate where sessions can take place. However, most telephone interviewees felt it was best delivered in a dedicated, ‘protected’ space:

‘Something very strange happens around when you, sort of, just allocate a particular room and it is just, it is somehow given more respect, it stays clean and tidy. It is completely magical, there is no real reason for why that should be, but when it is like an everyday space you just do not get the, you do not get that kind of barrier that you open through and walk into that calmer and more peaceful setting’ (TI8).

Sessions were delivered to a maximum of six residents in eight out of 13 cases reported through the survey, although additional responses suggested that Namaste Care was sometimes delivered to groups upwards of 15 residents. Views expressed by interviewees and roundtable discussions indicated that delivery could be to groups or individuals, but groups with more than 12 residents were less beneficial.

Session duration and frequency
Although some interviewees felt that Namaste Care was best delivered with two-hour sessions per day and set components, others favoured a more eclectic, ad-hoc, adaptable approach. The roundtable discussions also indicated that if Namaste Care was too prescriptive it could affect implementation by seeming less achievable. Concern was also raised that Namaste Care sessions could become tedious for residents and staff it they were too frequent.

The survey indicated that the prescribed programme of delivering a two-hour session twice a day for seven days a week was not being followed in many care settings. Eleven out of 12 respondents delivering Namaste Care reported that sessions lasted less than two hours, and in eight out of 11 cases only one session a day was delivered. Only five out of 13 respondents reported sessions being delivered seven days a week.

People who had seen, rather than delivered, Namaste Care sessions expressed a similar

<p>| Table 2. Summary of telephone interview participants including three participating in roundtables |
|---------------------------------------------|-----------------------------------------------|---------------------------------|------------------|</p>
<table>
<thead>
<tr>
<th>Job role</th>
<th>Role relating to Namaste</th>
<th>Area of the country</th>
<th>Length of interview (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistant nurse manager in nursing home</td>
<td>Practising Namaste</td>
<td>West Midlands</td>
<td>20</td>
</tr>
<tr>
<td>Registered manager of care home</td>
<td>Practising Namaste</td>
<td>East of England</td>
<td>27</td>
</tr>
<tr>
<td>Director of charity working with older people</td>
<td>Practising Namaste</td>
<td>London</td>
<td>40</td>
</tr>
<tr>
<td>Manager of hospice respite ward</td>
<td>Practising Namaste</td>
<td>London</td>
<td>36</td>
</tr>
<tr>
<td>Registered manager of care home</td>
<td>Practising Namaste</td>
<td>Yorkshire and the Humber</td>
<td>26</td>
</tr>
<tr>
<td>Head of older people and dementia/commissioner</td>
<td>Seen Namaste in practice</td>
<td>West Midlands</td>
<td>23</td>
</tr>
<tr>
<td>Admiral Nurse</td>
<td>Seen Namaste in practice</td>
<td>North West England</td>
<td>24</td>
</tr>
<tr>
<td>Self-employed practice development consultant</td>
<td>Seen Namaste in practice</td>
<td>London</td>
<td>43</td>
</tr>
<tr>
<td>Dementia care specialist</td>
<td>Seen Namaste in practice</td>
<td>Northern England</td>
<td>23</td>
</tr>
<tr>
<td>Occupational therapist with charitable organisation</td>
<td>Seen Namaste in practice</td>
<td>North West England</td>
<td>29</td>
</tr>
<tr>
<td>Self-employed trainer</td>
<td>Provides Namaste training</td>
<td>Yorkshire and the Humber</td>
<td>62</td>
</tr>
<tr>
<td>Trainer</td>
<td>Provides Namaste training</td>
<td>North West England</td>
<td>43</td>
</tr>
<tr>
<td>Trainer and project lead for charitable organisation</td>
<td>Provides Namaste training and support</td>
<td>North West England</td>
<td>19</td>
</tr>
</tbody>
</table>

Implications for practice
● Development of the Namaste Care Intervention UK should provide a consistent and coherent way to implement Namaste Care
● Implementation of the Namaste Care Intervention UK requires strong leadership
● Training is required for practitioners to ensure appropriate knowledge and support
● The Namaste Care Intervention UK should provide the flexibility to meet the needs of individual residents with dementia
view with six out of 16 respondents reporting one session a day, and the same number reporting two sessions a day. Sessions were delivered seven days a week in 11 out of 18 cases. Overall, this suggests that rather than being integrated into daily care, Namaste Care in the UK is delivered in a more fragmented way in at least some care services.

**Facilitators to implementation**

Interviewees expressed that Namaste Care should be supported by a whole organisational approach and led by someone influential, passionate and enthusiastic with the authority to implement change. They identified good communication and education as being fundamental to overcome negative attitudes.

The approach was perceived as needing to be underpinned by a working knowledge of person-centred care and understanding the concept and philosophy of Namaste Care was considered of equal importance to the practical aspects of delivery.

**Barriers to implementation**

A lack of time, space and resources and negative staff attitudes were identified by survey respondents as barriers for Namaste Care practice. The interviews reinforced this as the availability, attitude and perception of staff members were seen as threats to successful implementation. For example, one interviewee said, ‘everyone is so stretched; so busy’ (TI3), with staff often getting ‘stuck’ in the routine of the day and feeling under pressure. Managers are:

‘Always stuck with the tyranny of the urgent; space, lack of staff, trying to recruit staff to keep the place going, managers haven’t got time to think beyond that’ (TI3).

Lack of knowledge by other professionals and families was also perceived as a barrier. Those delivering Namaste Care commented that external professionals, including the regulator, seemed to have little information about the approach:

‘It surprised me that CQC took so little interest in it which made me think they have not really heard of it’ (TI5).

Equally, interviewees were worried that families could have a negative opinion of the approach:

‘[families] see it as the next step down in the progression […] they saw that people moved from Namaste to die’ (TI2).

This perception was, however, counterbalanced by positive stories of family integration into Namaste Care settings.

**Perceived benefits**

The survey revealed that, while practitioners and observers alike recognised difficulties when delivering Namaste Care, they recommended giving it a go, encouraging people to start small and build up if necessary.

Overall, Namaste Care was felt to improve well-being and quality of life for people with dementia, having a positive effect on emotional, physical and social aspects of their lives. This included reports that it had a relaxing and calming influence, made people more settled, less agitated, led to a more positive mood and more likely to smile. Respondents also felt it improved skin condition, hydration, weight gain, swallowing and sleep and reduced pain.

From a social perspective, respondents reported a greater sense of inclusion, more interaction between residents, and people were more responsive and communicative. Additionally, practitioners felt they were making a difference, which in turn improved job satisfaction. More widely, when other care staff saw the effect of Namaste Care for themselves it helped to change their attitude towards the approach.

**The culture of the care setting**

Although interviewees were not asked to comment specifically on the culture of the care setting, it emerged as a theme in their responses. They said that care staff seemed happier and almost relieved as Namaste Care was the type of care they wanted to deliver:

‘People want to do well by people and people care about people, want people to have a good quality of life’ (TI5).

Staff felt proud to be involved in Namaste Care and felt it gave them permission to be able to sit and ‘be’ with a resident.

Interviewees explained, however, that acceptance of Namaste Care as part of the care culture would require a fundamental change as people ‘have got to think differently’ (TI3).

There was a feeling among practitioners that Namaste Care should be provided as standard at the end of life but that it was still perceived as a luxury or additional activity. However, some felt that Namaste Care differs from usual care because it ‘focuses the mind’ (TI9) and is ‘very different from personal care’ (TI4).

**Discussion**

Feedback from the roundtable discussions indicated that participants were generally positive about the draft Namaste Care
Intervention UK, finding the overall approach to be comprehensive. Consequently, the proposed Namaste Care Intervention UK was finalised by incorporating the roundtable feedback. The overview of the intervention to be used and tested in the subsequent implementation research is provided in Table 3.

Responses to the survey and interviews also provided specific lines of investigation for the research. Survey respondents felt that Namaste Care could be appropriate for people other than those with advanced dementia. Additionally, Namaste Care is a relatively new approach in the UK, so inexperience among its practitioners would be expected. However, this raises important considerations about the need to support practitioners effectively and sustain the implementation of Namaste Care in the long term.

Differing views and inconsistencies in mode of delivery also indicate a need for more training for Namaste Care practitioners. This should provide clarity about the focus of Namaste Care, how it integrates with other approaches and the varied needs of people living in care settings. This is reflected in the three important issues emerging from the roundtable discussions. These are explored in the next stage of the study through monitoring implementation of the proposed Namaste Care Intervention UK in six case study care homes and are as follows:

1. **The parameters of Namaste Care**

   The frequency and style of Namaste Care required to achieve positive effects needs to be identified and described more clearly. A high degree of variation exists and a lack of clarity could result in important effects being lost or compromising buy-in from organisations and practitioners. However, any prescriptiveness should be balanced with the need for flexibility and ensuring that the intervention feels achievable by practitioners. Focusing on the boundaries of effectiveness and the process of getting to ‘optimal’ implementation in practice would therefore be a useful route forward.

2. **The practitioners and audience for Namaste Care**

   Appropriate participants for Namaste Care and the best ways in which a staff team can be enabled to deliver it need to be clarified. This must be considered in conjunction with understanding of change management and culture change in care organisations to ensure maximum success of any implementation.

### Table 3. The Namaste Care Intervention UK

<table>
<thead>
<tr>
<th>Component</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A beginning and an end</strong></td>
<td>Participants are welcomed individually into a relaxing and calm space at the start of a session. Towards the end of a session participants are activated through changes in the music, aroma and lighting</td>
</tr>
<tr>
<td><strong>The overall ambience</strong></td>
<td>The space is prepared in advance and attention paid to creating a calm, warm, welcoming and safe atmosphere</td>
</tr>
<tr>
<td><strong>Natural light and the ability to alter light levels</strong></td>
<td>Strong light levels are avoided, and it should be possible to adjust light levels. Additional atmospheric lighting may be used</td>
</tr>
<tr>
<td><strong>Specific and calming aroma</strong></td>
<td>Natural aromas are used rather than artificial ones</td>
</tr>
<tr>
<td><strong>Background sounds or music</strong></td>
<td>Gentle and relaxing sounds or music are used to create an atmosphere rather than providing entertainment</td>
</tr>
<tr>
<td><strong>Background visual stimuli on a screen</strong></td>
<td>Gentle and relaxing images are used to create an atmosphere rather than providing entertainment</td>
</tr>
<tr>
<td><strong>Physical comfort</strong></td>
<td>Comfortable seating is provided. Pain assessments are undertaken with individual participants before sessions. Levels of comfort are monitored throughout</td>
</tr>
<tr>
<td><strong>Expressive touch</strong></td>
<td>Closeness is communicated using touch, through activities such as hand massage, foot massage, hand and face washing, foot washing and hair brushing</td>
</tr>
<tr>
<td><strong>Food treats</strong></td>
<td>Opportunities are created so participants can experience favourite tastes, sensations and textures</td>
</tr>
<tr>
<td><strong>Drink/hydration</strong></td>
<td>Opportunities are created so participants can experience favourite drinks and ice lollies</td>
</tr>
<tr>
<td><strong>Tactile stimulation</strong></td>
<td>Opportunities to experience different touch sensations are offered, including soft blankets and fabrics</td>
</tr>
<tr>
<td><strong>Nature</strong></td>
<td>Opportunities are created so participants can engage with and experience nature such as plants</td>
</tr>
<tr>
<td><strong>Involvement of the family</strong></td>
<td>Families and visitors are actively welcomed to join the Namaste Care Intervention UK sessions</td>
</tr>
<tr>
<td><strong>Personalised music</strong></td>
<td>Playlists that are significant to individual participants are incorporated into sessions where appropriate</td>
</tr>
<tr>
<td><strong>Significant items</strong></td>
<td>Connection and interaction are enhanced by using objects that are significant to individual participants</td>
</tr>
<tr>
<td><strong>Use of dolls</strong></td>
<td>If participants enjoy interacting with or holding dolls, then this is incorporated</td>
</tr>
<tr>
<td><strong>Use of animals</strong></td>
<td>If participants enjoy interacting with or holding animals (live or toys) then this is incorporated. If in-house or visiting animals are available, these can be included in Namaste Care Intervention UK sessions. Robotic simulations can be used if already available</td>
</tr>
<tr>
<td><strong>Snoezelen/multisensory equipment</strong></td>
<td>If sensory equipment/Snoezelen environments are already available, they can be used in Namaste Care Intervention UK sessions</td>
</tr>
</tbody>
</table>
It will also ensure that the unique features of each care home’s resident group and staff group are considered, and improvements are driven for the whole home rather than in one specific area only.

3. Training, support and sustainability for Namaste Care
To achieve a consistent approach and ensure the intervention remains rooted in evidence and direct experience, methods for effective training and support for practitioners need to be developed; a challenge for such a disparate and low-resource sector. This training and support will need to occur alongside efforts to raise the profile of Namaste Care and its effects with important care home partners such as regulators and commissioners, so that investment in such an approach by care providers is recognised and rewarded.

Conclusion
Namaste Care is a promising and increasingly popular approach for caring for people with advanced dementia across a variety of care settings. However, practice in the UK is variable and exhibits a lack of coherence as to method and purpose. Despite this, those with experience of it are overwhelmingly positive about its effects and potential. Therefore, further research is needed to clarify the parameters and audience for Namaste Care and to establish the best ways to implement and sustain the Namaste Care Intervention UK. Later phases of the implementation study aim to explore these issues, learning from the experiences of six care home in-depth case studies. These will result in practical guidance for the UK care sector about how to implement Namaste Care in a way that is rooted in real-life experiences of care providers and people living with dementia.

References