GOOD PRACTICE IN GROUP CARE OF ELDERLY PEOPLE: ELTON HOUSE

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This paper offers an account of the philosophy and practice in one local authority home for elderly people. Over a period of about five years, changes have been introduced which have improved both the quality of life of residents and the job satisfaction of staff. Although still more remains to be done, the developments to date demonstrate how relatively simple this is to achieve, given clarity of purpose and good teamwork.

STANDARDS IN the residential care of elderly people have been much in the news over the past two or three years (Clough, 1987; NISW, 1988). They will assume still greater visibility when the government's White Paper (Cm 849, 1989, para.s 5.18-5.24) results in the establishment of independent inspection units for homes in both public and private sectors. Although the Government will push local authorities into promoting and making greater use of private and voluntary homes in the future, it remains a creditable aim for public sector establishments to lead the way in the provision of high quality care. After all, they are inevitably in the forefront of publicity when they get it wrong, as the reporting on the Nye Bevan Lodge revelations amply demonstrated.

This paper is concerned with the improved practice which has been introduced into one particular local authority home - referred to here as Elton House. (Its name has been disguised in order, primarily, to protect the privacy of residents.) By listening to residents' views, and by involving them in far more activities and choices about the way they want to live, the staff team has given them back their dignity. Such a move towards higher standards has to stem from an overall philosophy of care. The form this has taken at Elton House will be discussed after the changes which have taken place there have been broadly outlined.

If we begin to look in detail at the ways in which the quality of care offered at Elton House differs from that in the more depressing elderly people's homes, we know immediately what we hope not to find:

One of the strongest images of life in residential homes for the elderly is that of old people, relatively motionless, sitting around the walls of large sitting rooms. It me:) has to be said that this image, unfortunately, is not ill-founded and that most residents do spend the larger part of the day gathered together in such lounges (Kellaher et al., 1985, p.44).

Not only do elderly people in homes normally sit for most of the day, but they sit silently and always in the same chair which, according to Evans et al. (1981, p.4:15), can lead to petty disputes over seating arrangements 'usually related to territorial guarding of seats'. Perhaps this is a comment on how little other personal space the resident feels that he or she has within the home.

A few years ago at Elton house, the residents were indeed congregated round the walls while a large colour television talked to itself in a corner. The officer-in-charge decided, however, that people deserved better. He felt that people had a right to more choice as to whom they spent their time with or when to seek privacy, and that this could best be achieved through a limited change to a group living
approach. The first experiment worked so well that eventually three groups - of five, six and five respectively - moved into fully-fledged group living.

The advantages of residents being in smaller groups soon became obvious and staff began to raise money for room dividers to partition the large lounge into smaller areas. This was so that the other residents, though less independent, could nevertheless spend the daytime in groups of eight rather than in the large, impersonal crowd which used to prevail. Evans et al. (1981, p.2:4; 6:2-6:3 and 6:10) indicate that the arrangement of seats is clearly related to interaction and conversation with other residents. Friction between residents has been reduced, as have been the bottlenecks of Zimmer frames in certain parts of the building. Altogether, seven different day-time living areas have now been developed and there is also a quiet corner, with a sofa and chairs facing the garden, where residents can get away from their own group altogether if they wish. Again, Evans et al. (1981, p.2:5) comment on chairs being positioned in vantage points from which people can watch the comings and goings of others during their inevitably long periods of sitting still.

The more thorough going group living arrangements in residents involve mainly lucid residents who include, however, a number who are quite physically frail. One group has a blind lady and two other members in their nineties. One of the latter, though she is aged 93, has taken the reins in her group and sends the fitter ones on errands. Another group has one mildly confused member, another who is epileptic and has been in residential care for 38 years, and a third who has learning difficulties. One or two less able members can merge into a group and, indeed, one group rallied round and refused to let one of its number be moved when her condition deteriorated. The third group is regarded as very young because its members are aged only 65 to 86. No one joins a group without their agreement and, if they do not like it or cannot settle, they can move out again.

All three groups have only the minimum of staff support. Residents are encouraged to dust and hoover their own rooms, if they can manage it, which avoids the problem reported by Booth (1985, p.154) whereby many homes do not let people into or near their own rooms while cleaning is taking place, sometimes for the whole morning. Staff recognise that having the group living arrangements takes pressure off them because they have fewer domestic and physical care tasks to perform and because members of the groups take responsibility for one another, such as cutting up the blind lady’s food. The Personal Social Services Council (1980, para. 5.2), in fact, sees it as the right of residents 'to be considered as equal partners in the caring of the more handicapped residents'. Members of the groups also confide in each other. Problems such - as eating or sleeping difficulties are thus spotted earlier and are referred to staff before they build up into major issues. Booth (1985, p. 115) also suggests that small units are more comprehensible for potentially disorientated residents which may avoid another set of problems for some confused residents.

A Despite all now being based in smaller groups, residents are encouraged to visit other lounges and to invite someone lifestyle from a different lounge to come to theirs for a cup of tea. There has been a major effort to raise the funds for multiple new kettles and toasters so that each group can have its own. This allows people to make drinks and snacks whenever they like. Greenwell (1985, p. 15)
sees this as an important feature of a participatory lifestyle, and Kellaher et al. (1985, p.43) point out that residents may like to be able to offer a drink to visitors. Another advantage of having acquired the kettles and toasters is that breakfast can be taken at any hour and does not have to be taken as a communal meal. Bread, butter and marmalade, cereals and milk are taken separately to each group, or are fetched by a fitter resident, for people to prepare their own breakfasts. In accord with the home’s spirit of encouraging residents to help one another, there will often be one person who makes all the toast, or the pot of tea for his or her living group. All the living groups do their own washing up and keep the dishes, together with the tea and coffee, in their own living area. Booth (1985, p.152), reporting on a study which he carried out in 175 homes in four local authorities, remarks on the initially deceptive fact that more than three-fifths of the homes:

... had facilities where residents could make their own snacks or drinks whenever they wanted, including those which allowed them access to the main kitchen for this purpose .... Very often, however, the officer-in-charge commented that the facilities were rarely used, either because the residents were not competent enough or because they preferred to have the staff wait on them.

At Elton House, residents are also encouraged to use two small kitchens to bake for their living group, or even to plan, shop for and prepare a complete meal as, of course, this is far more feasible in a family sized group. One of the assumptions on which the philosophy of the home is based, is that residents should be encouraged to think about and help other people rather than being wrapped up in themselves. One man who had been in residential care for nine years and had become very depressed, tending to lie on his bed all day reading the newspaper, gradually rediscovered his extrovert nature and his experience as a foreman at work to become the informal leader of his living group. He also started to walk to a local shop each morning to collect the newspapers. The rest of his group gained from his organisational ability, previously submerged, while he, in turn, received the stimulation and companionship which eventually overcame his depression.

(NISW, 1988, p.60) emphasised that underlying the good practice does not develop unless it is based on the kind changes at Elton of careful reflection which results in ‘a shared philosophy House and values’. A number of clear principles underlie the changed practice at Elton House and these will now be explored. Broadly, they are as follows:

i. the desire to work with residents' strengths, not their weaknesses;
ii. greater tolerance of risk;
iii. increased choice and privacy;
iv. higher levels of personal attention from staff;
v. raised activity levels;
vi. links with the wider community;
vii. a commitment to obtaining residents' views.

No doubt, this is not a comprehensive list, but it does contain some crucial areas for consideration in any group care setting.

Working with residents' strengths
All too often, the focus in residential care of elderly people has rested predominantly on residents' weaknesses and failings. Any abilities or comprehension which they may happen still to retain either go unnoticed or else no opportunity is given for them to be used, so that they tend to wither or stagnate:

It is very easy to make the assumption that because people cannot do everything, they cannot do anything ... We must help people to retain their skills of decision making - it is about attitudes and values, resources come into it but underlying it is the approach of the residential unit as a whole -we ought to get the basic philosophy right. (Herbert Laming quoted in Morris, 1988, p.7)

Although a proportion of those in residential care are not at the extreme of physical or mental dependency (Booth and Bilson, 1988, p.12), rules and regulations, together with expectations, are frequently set to cater for the lowest common denominator in order to guarantee, that no one is placed at any degree of risk. Change may be resisted because it would make increased demands on staff, challenge ingrained attitudes and habitual behaviour, or because it would cost more (PSSC, 1980, para. 52). A typical example of this is the failure to take into account the needs of ethnic minority communities. (Brown, 1988), with the result that they are frequently under-represented and ill-served in residential homes.

Effectively, at Elton House, the view that it is easier for staff members to do everything for residents along rigid and time-honoured lines is now seen as fundamentally patronising and unhelpful. A new attitude towards caring has been introduced. Firstly, old age has come to be seen as merely a chronological fact and not as a basis for formulating a judgement about any particular person's capabilities or faculties. Each resident at Elton House is judged according to what they are able, with encouragement, to do and not in the light of any predefined assumptions as to what someone of that age ought or, more frequently, ought not to be able to do. Chris Phillipson (1982, p. 113) believes that older people themselves may need to be ‘deconditioned ’ about their own limitations since these are frequently stereotypical rather than actual. At Elton House, no one is assumed to need or to want a greater level of protection or help just because they happen to be over ninety. The 93 year-old lady mentioned earlier, for example, is in an informal leadership role within the home and takes on a good deal of responsibility for four or five people younger than herself. She is active to the extent of her capability and her limitations are accepted without being generalised to the rest of her functioning or daily living.

As Norman (1980, p.8) points out, 'patronising and paternalistic over-protection' prohibits self-determination and choice, whereas these remain very much on the agenda at Elton House. The role of staff has developed so that it is now seen as being to wait in the wings while residents do as much as they are able to alone. Staff do not rush in automatically to do things for residents, nor do they assume without asking that help needed yesterday - such as an arm to lean on or a wheelchair - will be needed today. They intervene only when the resident gives up and then often to urge him or her to go a step further. Alternatively, they may be able to encourage residents to help one another rather than to rely only on staff.

Greater tolerance of risk
In that the staff at Elton House expect not to offer help until it is clearly requested or needed, and because their role is seen as that of working towards the maximum participation from residents, their job is both more rewarding and involves a higher degree of risk than does a more protective model of institutional care. There is routine acceptance of things like residents having control over locking their own bedroom doors and being allowed access to kettles. In fact, as the residents in the living groups have aged, one group has asked not to be left to handle a kettle alone. However, this has not meant that they have had to accept complete dependency. They still perform many other tasks for themselves, such as laying the table and serving meals from the trolley.

The greater tolerance of risk is probably the most tangible difference between the atmosphere at Elton House and that in many other homes. Kellaher et al. (1985, p.51) suggest that at least a proportion of residents do not want to be over-protected and they stress the basic human right to take risks. The aim at Elton House is for residents to retain the maximum degree of independence and even to learn and develop new skills whenever possible. This fits in closely with one of the basic principles of good practice in the Wagner Report (NISW, 1988, p.60) where the opportunity for continued development is specifically mentioned.

This kind of change is only possible where there is good teamwork and support from management. Staff members at Elton House know that they are working in ways which are officially sanctioned and, indeed, which everyone working there has had the chance to debate and agree on together. There will not, therefore, be recriminations or unpleasant repercussions if a resident does get into difficulties through making what others might consider an unwise decision.

Choice and privacy

The topics of choice and privacy have always justifiably loomed large in studies of, and prescriptions for, the institutional care of elderly people (e.g. Evans et al., 1981; CPA, 1984; Booth, 1985; Kellaher et al., 1985; NISW, 1988). At Elton House, both issues have been given a great deal of thought, with the result that a large number of changes have been introduced.

Perhaps the most fundamental area of choice is whether to live in the home in the first place. Pre-admission visits are made whenever practically possible. Even in the case of the growing number of admissions from hospital, an extended settling-in period before any irreversible decisions are made (NISW, 1988, p.41) and an initial review, attended throughout by the resident concerned and significant relatives, help to ensure that the decision to come to the home and to stay there is freely taken. Ideally, the officer-in-charge would like to see prospective residents being allowed to try two or three different homes before choosing one to live in but this is not possible within departmental policy as it stands at present.

Food represents another fundamental area of choice. Those of us living in our own homes not only take choosing our meals for granted but regularly use them to celebrate, to welcome, to thank, and to play out any number of other social rituals and customs which are important to us. Yet, in residential settings, meal-times are all too often drab and regimented occasions offering little pleasure or preference and sometimes little nourishment to boot.
At Elton House, meals (apart from breakfast which was discussed at some length in an earlier section) are prepared by cooks in the main kitchen of the home but are fetched by an able resident or by staff and are brought on trolleys to the dining table in each separate living area. Lunch is chosen only a few hours in advance, so people are less likely to forget what they have selected. Not only can the menu, thanks to microwave ovens, include as many as eight to ten main dishes, but food can be kept back and cooked when a resident is actually feeling hungry. Tea is a lighter meal and individual tastes can be met - for example if someone asks for salmon sandwiches on a particular day. There is no problem in catering for special diets, whether these arise from ill-health, cultural or religious observances, or personal preference.

The flexibility over breakfast means that residents are encouraged to stay in bed as long as they want to and, for those who require assistance, getting up does not have to start at an unearthly hour (Morris, 1988, p.7). Bedtime is also completely optional, following residents' wishes rather than administrative or staff convenience. Some residents stay up until the early hours of the morning when they feel like it, or may choose to get up and watch a video if they cannot sleep. Night staff have been known to cook bacon and eggs during the night if someone is hungry. Each resident also has a bath according to choice and not a rota. Residents' relatives are encouraged to decorate their rooms and to help them choose soft furnishings to their own taste. This is in addition to any ornaments or furniture from the person's own home, which they are encouraged to keep.

As far as individual privacy is concerned, each resident has a key to his or her own bedroom door and, also significantly, staff do not go in and out of rooms uninvited or without knocking and waiting. A further extension of privacy can be offered in two shared 'bedsits' which have been adapted from staff living-in accommodation. These are completely self-contained and allow their occupants to lead an independent life, sometimes as a 'trial run' before moving into supported housing in the community. Over a two year period, ten people have been rehabilitated from Elton House in this way, including one lady who had had a massive stroke, followed by two years in hospital and a further two in residential care.

Personal attention from staff

In order to relate as closely as possible to residents, the care staff at Elton House operate a 'link worker', or keyworker system. This was introduced in recognition of the fact that having their responsibilities spread over all the residents had tended to feel impersonal and so demanding that staff tended to 'switch off their emotional responses. Instead of this, then, each care assistant is personally responsible for all the needs of three or four residents, be these physical, emotional or recreational. Physical needs include bathing (which is therefore done by a consistent person and is less intrusive upon privacy) and replacing clothes. The link system and the ethos in the home make it possible for residents to choose their own clothes, preferably by going on a shopping trip with 'their' staff member, or by asking her to collect something from a preferred store. From time to time, the link worker will help a resident to sort out all his or her clothes and decide what to keep and what to replace.
The link system is designed specifically to mean that staff set time aside to concentrate on talking to residents. Greenwell (1985, p. 14) sees it as a good way to 'provide for special relationships to occur between residents and staff and also to ensure that someone who has newly arrived is helped to settle in. The fact that residents do as much as possible for themselves and for each other means that staff have more time to spend on residents' social and emotional needs. Also, staff are encouraged, if they want a cup of tea or a cigarette, not to 'float off somewhere', but to go and sit in a lounge where residents do not object to smoking to have a fag and a chat together.

Evans et al. (1981, p.4:7) found that 76 per cent of care staff and 95 per cent of supervisory staff felt more time should be spent on the social care of residents, the care staff highlighting domestic duties as the main obstacle to this. These authors conclude: 'Indeed the main issue that seems to arise out of these results is the low level of contact that exists between care staff and residents, other than in the form of providing purely physical care'. Kellaher et al. (1985, p.45) reflect on the same difficulty:

Staff have very little time to interact with residents. They can rarely sit down for half an hour to an hour to talk about the things that interest the resident.

At Elton House, on the contrary, the firm expectation is that staff will find at least half an hour per day to spend with each resident in their link scheme. They have certain times of the day when this should be clearly possible, including an hour before lunch and all afternoon. Only a major upset to normal life there, such as nursing a resident through the last few days of their life, would interfere with this way of working. And, incidentally, the body of a deceased resident is not slipped out the back way during the night as if they had never existed. Deaths are acknowledged and grieved over by residents and staff together.

Raised activity levels

There is a further expectation at Elton House that, at least once a week, each member of staff will undertake a shared activity with their whole group of linked residents. The residents are deliberately drawn from different living groups throughout the home so that they see some other faces apart from the familiar ones from their own lounge. These group activities might include a craft, a topic based discussion, or a reality orientation exercise. All are directed at engaging residents' attention and concentration, encouraging them to interact with each other, and stimulating them intellectually. Evans et al. (1981, p.6:5), through a series of observations of residents in six homes, made the frightening discovery that only 31 per cent of them were engaged in any purposeful activity:

Thus more than two thirds of residents might be expected to be disengaged during any part of the day. Most people spent the greater part of their daytime hours sitting, gazing into space or dozing (Evans et al., 1981, p.6:5).

Sad to say, the arrival of a cup of tea, at rigidly fixed points in the day, caused the only major peaks of activity which they were able
to observe.

Other activities at Elton House involve larger groups of people. The staff are encouraged to bring in slides of their holidays and, as a result, one disorientated man with Parkinson's disease, who suddenly showed a great interest in slides of the Vatican, was found to have made a life-long hobby of visiting art galleries to see paintings and sculpture. This opened up all sorts of possibilities for engaging his future interest. Pictures, objects and memories of the past are used to stimulate lively conversations with residents along reminiscence therapy lines. The spacious grounds are well used in better weather by residents walking or sitting outside. There is also a putting green, and two or three residents take an interest in the greenhouse where they grow tomato plants.

Staff do organise holidays, weekends away and daytime and evening outings but relatively few residents seem to want to go beyond the confines of the home. As an alternative, staff bring in different forms of entertainment once or twice a month and concentrate, in other ways, on bringing the outside world into the home.

Links with the wider community

A good deal of work has been devoted to forging and maintaining links with the local community. Although it is found to be easier to recruit volunteers to offer practical help, the emphasis is put on finding people who are willing to visit on a regular basis to talk to residents.

Ingeniously, local people and relatives of residents are encouraged to get to know Elton House by making available for general use, as well as for residents, a barbecue pit and the putting or croquet lawn. Another feature of the home's life which has been consciously developed has been opening a bar and becoming licensed as a social club. Regular social evenings are held there, to which relatives and local people are invited to come and to bring their friends.

The officer-in-charge's vision of the future would be to open the home up as a resource centre for the locality so that, for example, elderly folk from the town could come in during the afternoons, not for formal day care but to take part in activities run by volunteers. This would improve the social life for residents whilst, at the same time, giving local people a place to meet and the chance to see what an old people's home is like well before needing to contemplate going to live in one. Another aspect of the idea is to run a carers' advice centre for those looking after elderly relatives at home. This is a similar idea to that expounded by Kelly (1987, p.20), who sees it as a way of blurring the boundaries between the institution and the community while using resources more efficiently. Other ideas of Kelly's for involving the public include an open lunch service, pre-retirement courses, cultural events, and offering the use of facilities ranging from a dark room to rooms hired out to the public.

Obtaining residents' views

Any improvements in the quality of life in a group care setting have to start from listening to what residents say is important to them. (Marsh, 1988, for example, gives a rarely expressed consumer's view.) In the same way as remaining capabilities are still respected at Elton House, so are residents' opinions about the way they wish to be
New residents are always addressed as Miss X, Mrs Y, or Mr Z unless and until the resident suggests otherwise (Centre for Policy on Ageing, 1984, para. 2.3.5). The participatory style of care which is practised at Elton House, the staffs emphasis on talking to residents, and the introduction of discussion groups have all encouraged those whose home this is to comment on the way it is run. Even the most confused person is considered to be able to make useful observations on his or her quality of life if sufficient effort is made to understand what is being said or indicated in some other, perhaps non-verbal way. The willingness to make that extra little effort is a crucial part of the home’s ethos.

One activity at Elton House, which a link worker occasionally holds with a group of residents, is a ‘groan session’ about the home itself. A residents’ committee was tried for a time but staff felt that the six residents who served on it did not consult the others, passing on instead only their own views on the matters raised. It has emerged clearly from developing models of participation in a range of settings, however, that those involved need training in the skills of effective consultation and representation (Beresford and Croft, 1989), so perhaps the idea could be tried again in the future. Meetings of residents are still held to discuss how to raise and spend money, so they are formally involved in some decisions affecting the whole home, though within clear boundaries at present.

Any dissatisfaction with the way things are done at Elton House is picked up largely individually, for example through the link system. In addition, regular reviews are held on each resident and he or she is invited to be present throughout. This is still not common practice everywhere and one opinion is that this results from:

... the fear and threat that their attendance poses to the experts who dress their fear up in the ageist rhetoric of.. ‘it would only upset them’. What they really mean is: ‘it would only upset us’ (Unwin, 1988).

When a resident chooses not to attend a review, the liaison fieldworker from the area office, being someone independent of the home, seeks the individual's views and puts them to the meeting. This sometimes involves raising a problem such as someone not liking a fellow resident, or worrying about a relative who has not visited recently. The review will allocate responsibility for sorting out the difficulty. The officer-in-charge and the liaison officer also meet regularly to deal with similar sorts of issues as they arise or are identified.

The link system is used to pass on news about anything happening in the home and to seek reactions from residents to any proposed changes, although it can be much harder to obtain views than to impart information. Scrutton (1986, pp.20-21) discusses at some length the reasons why it is difficult to encourage elderly people to complain to their carers, both in their own homes and in residential care. He blames the fact that they know they are seen as an unproductive burden on the economy, that working class elderly people were brought up to 'know their place', that the very need for care makes it impossible to 'strike the hand that feeds', and that elderly people accept bereavement and loss as 'the accepted price of old age' so have very low expectations of the quality of their lives. What is more, in residential care states Scrutton, residents are typically required to conform and, if they do complain, may be variously
labelled 'awkward', ignored, seen as ungrateful and responded to with anger, or even prescribed tranquillisers for 'irritability'. In the light of all this pressure against genuine feedback from residents, Scrutton advocates both the kind of regime which is seen to welcome and act upon comments from residents, and an 'accepted channel' to air views, such as a residents' committee, provided that it is more than a talking shop.

How the changes were introduced at Elton House: management issues

It is only fair to say that the changes and the new philosophy at Elton House were introduced largely on the initiative of the officer-in-charge because he had a certain vision of the way he wanted things to be done and strong views about how they should not be done. Doing a good job of caring for people physically was not enough; their emotional and intellectual needs should also be met and they should be treated as people first and foremost. Although the philosophy was entirely sound, this was not an ideal model of change because it started from the 'top down' rather than from the 'bottom up'. Initially, many staff members were sceptical both about the value and the feasibility of the proposed changes, and it was only the charisma and energy of the officer-in-charge which persuaded them to give it a try.

Julia Phillipson classically draws out the tensions in this situation in a preamble to her description of her own programme of training for all staff in one local authority's homes:

...the skills in nurturing and mothering which women develop as a result of socialisation, education and often direct experience, are also major elements in jobs that have long been the chief source of employment for women, particularly for those with limited educational experience or from minority ethnic backgrounds...

... In parallel to this, some policy makers and senior management (typically men) believe that many care staff are doing it wrong - skills of looking after dependants are deemed as inappropriate because of the resultant infantilisation and culture of passivity, whilst too much tending is seen as depersonalising... In addition to the ambivalence about caring and how it should be done, there seems to be a failure to fully understand the complexities of caring and the impact of sexism and racism, which relegates much of caring into low skilled, low status work carried out by women (Phillipson, J., 1988, p.4).

It is important, therefore, that managers should value their staff as well as their residents by involving them fully in discussing and deciding how change should take place. Good practice will not come about where the members of an overwhelmingly female and notoriously exploited workforce are left to fall back only on their own personal experiences as carers, but nor is it fair to regard them as 'the problem' without engaging them in a positive process of change in which they have a real say. Unless they themselves are accorded respect, for example through the right to play a full part in planning and developing the work of the home, care staff cannot be expected to engage actively in fostering a regime of care which is respectful of the rights of residents. Perhaps the development of higher standards of care may, in turn, help to raise the status of the caring task itself so that a mutually reinforcing cycle is set up.
At Elton House, what happened was that pilot changes (notably the introduction of the first group living arrangement) were put into effect on the boss's 'say so' alone but were so successful that they soon won staff over to actively participating in implementing the changes more widely. They quickly began fund-raising for individual kettles and toasters for the different living areas, for example, and for partitions in the lounges. The care staff, whether doubting or supportive, were always listened to, with formal staff meetings taking place regularly and additional informal meetings held with each shift. The change to group living and the overall philosophy underpinning this was soon introduced onto the agenda of these meetings and became increasingly the property and responsibility of the whole team, not just of the officer-in-charge. Overall, the changes came in over a period of approximately five years which was gradual enough to carry everyone along, without leaving people feeling that they had been forced to accept policies they did not want or did not believe could work. In addition to this development of teamwork, there has always been quite a high commitment to training at Elton House. Its importance is borne out by the fact that training issues appeared in the formal evidence received by the Wagner Committee almost twice as often as any other subject (NISW, 1988, p.85). The Elton House staff have had opportunities to go on in-service training courses on issues relevant to the new philosophy of care in the home. They have also had regular staff development meetings with their homes’ adviser to discuss the changes in which they are playing such a crucial role. This has had the added advantage of allowing them to feel supported in their work, knowing that they will not be blamed if residents’ greater independence and risk-taking lead to any mishaps.

Elton House does not represent a perfect example of residential care of elderly people, nor a perfect model of change, and it has not been the purpose of this paper to ‘knock’ those who are doing a hard and often thankless job by suggesting that others are doing it better. Rather, I have tried to show that, even working against the odds, a level of change is possible which can greatly improve the quality of life for residents.

They think if you’re old, all you want to do is sit and stare at the wall. It isn’t true. And people will shout at you as if you’re deaf and hadn’t got all your wits. Nine out of ten do it. They condescend. They treat you like children. Children and old people are not races apart. We’re all human. We have the same needs as anybody else (recorded from a conversation with an elderly person by Seabrook, 1980, p.64.).

There are, of course, many additional advances which can be made in caring for elderly people, over and above those which have been outlined here. They include involving residents in the selection of staff (Morris, 1988), building up self-advocacy initiatives to give residents a collective voice (Flower, 1983), and implementing the list of objectives produced by the Wagner Development Group which was established by NISW to hasten improvements in residential care (Community Care, 10 November 1988). These objectives include: the introduction of brochures setting out the aims in particular homes - which aims should in any case be annually reviewed - and of contracts covering residents’ rights to keep personal property, to have some security of tenure and so on, the establishment of complaints procedures, and the implementation of equal opportunities policies in
staff recruitment.

Nevertheless, Elton House does provide one example of good practice. It may encourage others to think about an ethos which can underpin what they are wanting to achieve with residents and be followed through into every aspect of the running of the home. Perhaps the best reflection on the staff’s success to date at Elton House came from a secretary who typed an earlier draft of this paper. She asked me where the home was, because her own father was likely to need residential care very soon and this sounded like somewhere where she thought he would be happy to live. I am sure that can be regarded as praise indeed.

References


