Briefing home care staff about older people's individual needs

RESEARCH works

Home Care staff need background information about each older person whom they visit – about frailties and health problems to which they should be alert and about particular needs and concerns voiced by the client. Inevitably some situations arise when Home Care staff must visit people whose circumstances they do not already know. This joint project by SPRU and Bradford Social Services Elderly Division explored a method for keeping staff well-briefed through documents, which complement Care Plans, kept in clients' homes for any visiting Home Care worker. A test of the method showed that.

- Service can be improved through simple written briefings, kept in clients' homes, about clients' needs, vulnerabilities, preferences and any special requirements.
- Home Care Assistants valued these briefings and found them easy to use. They wished them available in more clients' homes.
- It is always worth asking clients specifically about any personal preferences or requests relating to service quality. New information can be gained even from long-established clients.
- The briefing method seems especially promising concerning new clients, clients with communication or cognitive difficulties, and for new staff, temporary staff and staff returning from absences. The test also found instances of useful information in briefing documents concerning the full range of clients.
- This method can affect actual service. Changes were soon made to some clients' services as a result of the briefing system.

RESEARCH FINDINGS FROM THE SOCIAL POLICY RESEARCH UNIT

SPRU

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Background

Earlier research in Bradford found concerns that Home Care staff were increasingly having to work with clients whom they did not know well. This reflected the Home Care Service's new focus towards more dependent clients, who need multiple daily visits – a common trend nationally. There were fears that staff might become less able to monitor clients' well-being. Also they might miss opportunities to help clients to resume some daily living tasks themselves.

Also, interviews with clients showed that individuals differed widely in what they said would give their service added quality. There seemed opportunity for increasing client satisfaction if staff knew what mattered most to each person.

Care Plans typically listed tasks. They gave little background for working with an individual.

The Project

A test was undertaken of a staff briefing document kept in clients' homes. It comprised a set of facts about each client, plus a record where staff logged each visit. The documents were managed by Home Care team leaders. Copies of the briefing information were also held by team leaders to assist planning and supervision. After the test, the briefing document was condensed to the elements in Figure 1 and introduced by Social Services.

Figure 1
Components of the staff briefing documents, as revised after evaluation

- Main reasons for service/results sought from service
- Specific changes to work towards
- Changes to watch out for
- Special requests from service user
- Other important information
- A profile of a client's expected abilities for daily living tasks
- A 'Daily record' where every visit is entered: times, staff names, tasks undertaken, observations and messages to other workers.

Findings

Views of Home Care Assistants

Overwhelmingly Home Care Assistants wanted the briefing documents used more widely – many wanted them for all Home Care clients. They found them easy to understand, often useful, often bringing fresh information and not time-consuming.

> *"Knowing beforehand from reading the Briefing Sheet, you seem to give a more friendly approach, as if you are very familiar with this particular client and can talk about their problems, etc."*
> (Home Care Assistant)

What the briefing documents communicated: results from the test

'Main reasons for service/results sought'

Often this section carried background information like a client's disabilities, recent hospital admissions, cognitive impairments and communication difficulties, or the disabilities of their spouse. As well as Home Care staff needing such information, clients interviewed earlier had said they wanted staff always to know why they were getting help. Instructions to staff for filling in this section should supply examples *(like Figure 2)* because otherwise minimal, uninformative entries may be made instead such as 'To help client remain in her own home'.

Figure 2
'Main reasons for service /results sought from service' An example.

"Mrs B suffers from arthritis. Is trying very hard to keep her independence and mobility. Walks with stick and suffers dizzy spells, resulting in falls. To support her with pension and paying bills."

'Changes to work towards'

This section was intended to highlight any specific short-term goals. As expected, it was used only for a minority – about one in five of these clients. It was sometimes used to instruct staff to support physiotherapists – by prompting rehabilitative exercises in one case and by encouraging daily living activities in another. Another use was to instruct staff to repeatedly advertise carers' services to a family carer. In another example, the section was used to prompt staff to repeatedly offer house-cleaning in a case where this was needed but resisted by the client.

'Changes to watch for'

This section was very widely used, frequently concerning health problems or a client's vulnerabilities. For example for one client staff were told to watch for ear infections which led to balance problems, resulting in falls. Another example was instructions to staff to keep checking that a client was still receiving substantial help from a neighbour, without which her care would need to be revised. The section was also used to monitor improvements – like possible improvement in a client's mobility, which might mean that service could be reduced.

> *"If this client is not sitting on the side of the bed when Home Care are ready to leave, then she may well be ill."*
>
> *"Miss C is 95% blind, lives alone and has no next of kin. Any suspicion of total loss of sight to be reported and input increased."*
>
> *"Client is very hard-of-hearing. Any phone-calls which client needs making, Home Care please make for client."*
>
> *Examples of Information in Home Care Record Book during the test*

'Special needs/requests'
Clients were invited to name any individual preferences, including preferences which the service already took into account. Figure 3 lists their responses. Some preferences turned out to be fulfilled already but there were others which were first identified through this exercise, including among long-established clients. Some of these requests were met as a result. Others were not – for instance requests to be served always by the same staff member are difficult due to the way these Home Care teams are organised. Staff were encouraged to devise compromises concerning difficult requests – for instance to provide a preferred visit time on some days even if not on all. Preferences which cannot be met can be recorded and placed on the service's agenda for development. Some clients expressed no requests or preferences.

Figure 3
Clients' preferences or requests during the test of the Home Care Record

- Five requests concerned changes to the timing of Home Care visits.
- Four people sought the same Home Care Assistant for a week or a month at a time.
- Three people wished staff to spend more time with them during a visit.
- Two people wanted their shopping or pension collection be done on different days.
- Other requests, named only by single clients:
- Help to find honestly priced gardening, electrical and plumbing services.
- More help whenever family are on holiday
- One extra daily visit from Home Care
- Temporary extra help after leaving hospital.
- Would like cooker always wiped after use.

For which situations did the briefing document seem most useful?

In the view of Home Care staff, it is especially useful for new clients, new staff, temporary staff or when staff returned from absences and for clients with communication or cognitive difficulties. But there were signs of its potential for all categories of client. While there was more information entered on documents for people receiving intensive service, there was also much valuable information about people who received only a single visit per week.

Actual changes occasioned by the briefing document

During the short test period, improvements were made to the services of five clients as a direct result. In three cases this reflected information about client preferences, while in two cases it resulted from the section: 'Changes to work towards'. However many of the briefing document's entries concerned prevention of problems through increasing staff awareness of clients' needs. These often would not produce clearly identifiable changes.

Sensitive information

Some staff identified important information which was too sensitive to place in a client's home. An example was that a new client was suffering from dementia, though she did not recognise this, and that staff should watch carefully for household problems which suggested further decline. Some sensitive information will need to be communicated to staff through other means, like verbal briefings. But a Home Care Organiser illustrated ways sensitive topics sometimes could be handled through very carefully worded messages on the briefing document.

Operating the system

It had been intended that the system would function as follows:

- The briefing document would be 'owned' by the Provider. Provider managers must be able to change the document rapidly to update their instructions to their own staff.
- For a new client, the briefing document would initially be filled in during the Provider's assessment. It was expected that some sections, like clients' requests, might sometimes need to be expanded later on by the Home Care team leader, once the team and the client knew more about each other.
- The briefing document would be read by Home Care Assistants, who would also make entries in the 'Daily Record' section.
- The briefing document would be regularly reviewed and modified by the Home Care Assistants' immediate team leader. Many small changes to the document are likely in the long-term, considering how much older people's needs may change over the years. The document was intended to be quicker to update than the Care Plan.

In practice it seemed easy for the Home Care Organisers, who conducted Provider assessments in this service, to start new clients' briefing documents as part of assessment. Home Care Assistants likewise proved able to undertake the role envisaged for them. But the brief test period gave no information about maintenance of the document by Home Care team leaders.

A problem became evident concerning any mass introduction of these briefing documents. To obtain enough clients for a rapid test, most of the sample were established clients and hence their Home Care team leaders needed to start the document for them as well as maintaining it. This proved a much greater time-burden for team leaders than expected. Even for established clients, starting a new briefing document requires direct discussion with clients and family, just as in an assessment or review. The task would

best be combined with routine visits which the team leader would be undertaking anyway. It could be hazardous to require many extra visits by team leaders in an attempt to complete mass introduction of the briefing document very rapidly.

As far as can be judged from this brief test, routine operation of these briefing documents should not cost great staff time. But caution is needed if initially introducing them for all established clients.

early breakfast was met. Team leaders' copies of briefing information were occasionally used in team discussions, staff supervision and client reviews.

Audit of the entries on these briefing documents also seems worth exploring. For instance teams could be compared concerning the types of clients' requests which staff are being told to fulfil. Audit seems advisable during the introduction of the documents, to check that they are being filled in with the types of information intended.

Implications and areas for development

Briefing documents of this type could be used by any Home Care service, whether Local Authority or Independent Sector. They are increasingly necessary as Home Care services concentrate on older people with very pronounced frailties, who traditionally might have received residential care instead. These clients need much more frequent visits, hence more staff are involved with each client, and clients have more complex needs. Also, in any service, however organised, there will always be some new clients, new staff or some temporary assignments of staff to clients whom they do not know.

If Care Plans are already kept in clients' homes, Authorities should not assume that these contain all information which Home Care staff need. A sample of these Care Plans could be examined to investigate this.

Areas for development

These briefing documents merit exploration as a tool for individual client reviews. Headings like 'Changes to work towards' or 'Special needs/ requests' could offer helpful focal points in reviews, which may then be used to update the entries. Sometimes, too, the Daily Record may show how far such entries are being acted on or what results are being achieved. For instance, during the test described here a team leader studied the Daily Record to check how often a client's request for an

Methods

The briefing documents were tested with 27 older Home Care clients during two months in 1999. These clients were served by five small teams from Social Services' Home Care Service. They were predominantly established users of the services, plus some new clients arriving during the study period. To compare effects, the established clients included people receiving intensive Home Care and people who usually received only one visit per week.

The evaluation comprised:

- Analysis of the entries in the structured briefing document
- For each client, a written assessment by their Home Care team leader of any consequences from the exercise plus any feedback from the client or their family
- Written questionnaires to Home Care Assistants
- Written questionnaires to the five team leaders and their line managers
- A tape-recorded discussion with the team leaders and their line managers

Following an evaluation report in September 1999, the document was modified, then introduced by Social Services within a new Home Care Record Book for the whole District.

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Further information

Copies of Bradford Social Services Home Care Record Book can be obtained from: Ruth Woller, Home Care Administration, Bradford Social Services (North), 438 Killinghall Road, Bradford BD2 4SL. Tel: 01274-631751 Fax: 01274-626614

The following are available from SPRU's Information Office. Please contact Lindsey Myers, Information Officer, on 01904 433608 or email **spruinfo@york.ac.uk** for further information.

The following *Research Works* summarise work undertaken by the Outcomes Programme:

Introducing an outcome focus into care management and user surveys

Outcomes and assessment with older people

Briefing home care staff about older people's individual needs

Learning from older community care clients

Implementing an outcomes approach to carer assessment and review

Evaluating the outcomes of social care using postal questionnaires

All *Research Works* are also published on SPRU's website: *www.york.ac.uk/inst/spru/pubs/research_works.htm*

Recent work of the Outcomes Programme is reported in the *Outcomes in Community Care Practice Series.*

Number 5 *Overview: Outcomes of social care for older people and carers* by Hazel Qureshi, Charles Patmore, Elinor Nicholas and Claire Bamford, £4.00

Number 6 *Outcomes of social care for disabled people and carers* by Claire Bamford, Hazel Qureshi, Elinor Nicholas and Ayesha Vernon, £4.00

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