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Project Paper

NUMBER 73

Issues in the registration of private nursing and residential homes

HELEN SMITH

ISSUES IN THE REGISTRATION OF PRIVATE NURSING AND RESIDENTIAL HOMES

A report of two conferences held at the King's Fund Centre

by Helen Smith

King's Fund Centre

Introduction

This document is a report of two conferences held at the King's Fund Centre on 17 October 1986 and 26 March 1987. The programme was virtually the same for both conferences; a copy of the programme is contained in the Appendix.

The aim of the conferences was to provide, as Professor Johnson states in his foreword, a 'neutral forum' for owners of homes and registration officers to discuss joint problems and to further good working relationships. This report marks a stage in the growing debate between owners and inspectors and will, we hope, serve to stimulate and contribute to the growing discussions and collaborative efforts of the different groups.

Helen Smith
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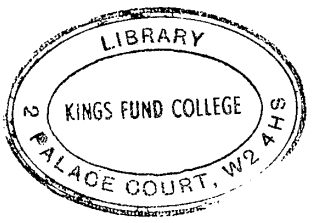
June 1987



Printed by Jayo Print and Marketing Ltd

ISBN 1 870551 02 8

King's Fund Publishing Office
2 St Andrew's Place
London NW1 4LB

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Acknowledgements

Many thanks to Professor Malcolm Johnson for his help and support with the conferences and the project paper. I am grateful to the people who planned the original conference; that is, Chris Beddoe, Roger Marchant, Alison Norman and Alison Philips.

I would like to thank the speakers for their lively and stimulating contributions to the conferences. I would like to thank the following people who facilitated the small group sessions and made them such a success:

17 October 1986

Sue Benson	Editor, Care Concern Magazine
Roger Marchant	Registration Officer, Waltham Forest Social Services
Alison Norman	Senior Policy Officer, Centre for Policy on Ageing
Sheila Peace	Research Fellow, Centre for Environment and Social Studies in Ageing
Roz Rawlins	Counsel and Care for the Elderly
Lindsay Royan	Clinical Psychologist, Enfield Health Authority
Linda Thomas	RCN Advisor in Geriatrics, Royal College of Nursing

26 March 1987

Sue Benson	Editor, Care Concern Magazine
Sally Day	RCN Advisor in Nursing Management, Royal College of Nursing.

Pauline Middleton	Assistant Director, British Association for Service to the Elderly.
Mrs Oxley	Shrewsbury Social Services
Roz Rawlins	Counsel and Care for the Elderly
Tom Richards	Age Concern, England
Mrs D Smith	Shrewsbury Social Services
Rolf Veling	Registration Officer, Barnet Social Services

I would like to thank Mrs J Spiers and Mr D Woodland from the Registered Nursing Homes Association for their contribution to this conference.

Foreword

To speak of the residential care field as being in a state of transition would be an understatement. In the care of elderly people, but also in provision for people with mental handicap, there has been an explosion of non-statutory establishments. Already the traditional suppliers of residential and nursing home facilities have been displaced from their position of dominance. Indeed, they have been relegated to a minority position. On the basis of current trends, the private sector will become the majority supplier by the end of this decade. Even in the language of realism this can be deemed a revolution.

Like any rapid transition of a radical kind the changing pattern of residential and nursing home care has been both problematic and, for some painful. The twin engines of change, demography and government, have contributed quite different forces. Shifts in the age structure have resulted in a population of people over eighty which is unprecedented in the whole of human history. Despite warnings by students of population two decades ago, there was little preparation. As a consequence beleaguered local authorities were unable to meet the demands, leaving the private sector to cater for a growing market.

Government's role has been less predictable and altogether more complex. On the one hand clarifying legislation and associated codes of practice have proved to be necessary and useful devices, but ones which have caused their own ripples of ambiguity and inconsistent application. On the other hand, the unplanned but efficacious availability of social security funds to support residents in private homes, further encouraged the expansion which was already in train. Just as estate agents were viewing every large period house as a potential gold mine of social security supported residential accommodation, the weekly rates were cut back. Existing providers catering for this slice of the market had their financial planning undermined. Suddenly this kind of small business was no longer the panacea for early retirees and entrepreneurial caring professionals.

The 1984 Residential Homes Act consolidated and extended the existing law. It introduced more elaborate registration and inspection regulations and levied a charge on proprietors which was enough to irritate them, but too little to meet the local authority and health authority costs of the system. Through the introduction of two very different codes of practice (one for residental and the other for nursing homes) there was a polarisation of styles, living regimes and staffing. In residential homes the legislative package emphasised single rooms, private spaces, personal dignity, control of own money and drugs by residents. In nursing homes it meant more trained staff, strict procedures for the control of medications, little about personal space and dignity.

As the two modes of provision were placed in greater contra-distinction to each other (though often dealing with the same pool of elderly people) and competing for business, their representative organisations became more at odds. In the middle of their unease about the new Act and regulations, there was an ill-considered gremlin, the statute introduced the notion of dual registration.

Except in circumstances where the two forms of care and living were physically separate, there was considerable uncertainty about how dual registration could operate. Nursing homes proprietors began to claim that all elderly residents/patients needed nursing care and therefore there was no legal role for residential homes. A counter argument started that residential homes were committed to the 'home for life' approach and that even sick residents should receive whatever care they needed without having to move. Where necessary, health authority or other domiciliary nursing could be introduced just as the individual would receive at home.

Concurrent with the disputes about who should do what there was growing concern about quality of care. As a guarantee to the consumer and with a genuine desire to provide good service and value for money, much effort went into developing greater sensitivity to the needs of residents, staff and proprietors. Enlightened proprietors experimented with new patterns of treatment and residential living. The private sector healed its breaches and joined in a strategy for staff training in caring and management.

The Kings's Fund Centre which has provided a neutral forum on private care since the turn of the decade - well before others even observed the need - has continued to spot the rising issues and stimulate debate about them. The conference reported in the following pages shows how valuable this resource has been. Helen Smith (Senior Projects Officer) anticipated the need to clarify the conflict of views about registration in the two areas. Not only was the meeting over-subscribed, there were enough applicants to demand a complete re-run several months later. For those who attended there was a day of informed straight talking with any latent hostility, tempered by a desire to find sensible solutions.

Reproduced in this report are the texts of the main presentations. They represent the current state of play. On the one side a struggle to provide interpretations of the rules which are reliable and fair. On the other, imaginative and flexible approaches by registration staff and homes owners to providing the sort of care elderly people need. It was my privilege to chair the meetings. They were challenging and interesting occasions. I hope that others will discover some of their vitality along with information and analysis, as they read the report.

Professor Malcolm Johnson
Department of Health and Social Welfare
The Open University
June 1987

CHAPTER 1 - INTRODUCTION TO PRIVATE SECTOR CARE FOR ELDERLY PEOPLE IN BRITAIN

In a survey of private and voluntary residential and nursing homes undertaken for the Department of Health and Social Security in 1985[1] the following findings were reported; they provide the background context for the conference.

Nursing Homes for the Elderly

Private nursing homes cater for a wide variety of patient categories including post operative, convalescent, medical and surgical cases, the chronic sick and the terminally ill. Hospices and hospitals are also registered as nursing homes. The number of independent or private nursing homes increased slowly until 1980, when there were 34,500 places in all categories of nursing homes, including private hospitals. Between 1980 and 1984 nearly 6,000 additional places were added and 300 new private nursing homes and hospitals were opened with an increase in bed capacity of 17%. Statistics collected by the Registered Nursing Home Association (RNHA) indicate that about 76% of the total private sector beds were for 'general medical, geriatric and convalescent' patients'. This meant 30,000 beds for elderly people in 1985. (This estimate, however, should be viewed with caution, as beds used by elderly patients are not categorised separately in statistics, and are merely inferred from other statistical information). Prior to the Registered Homes Act (1984) there had been much overlap in the market between nursing home services and the residential homes, including local authority Part III homes, especially for elderly people who were more independent. In the past then, nursing homes catering for the elderly had not been sharply differentiated from residential homes. However, the 1984 Act caused a greater public awareness of the differences between residential and nursing homes, and the client group for each adjusted accordingly. It would seem, in simple terms, that patients in nursing homes now appear twice as dependent as people living in residential homes. Approximately 25% of the staff input in private nursing homes is by trained nurses, 40% is by nursing ancillaries and 20% by domestic staff. Approximately 68% of private nursing homes for the elderly are owned by a nurse or the spouse of a nurse. Given the increasing numbers of elderly in the population aged over 75, and an emphasis in many health and local authorities on assessment and treatment rather than long term care, it is almost certain that there will be a continuing increase in the demand for private nursing home services.

Residential Homes for the Elderly

Residential homes for the elderly provide residential care; that is, accommodation, meals, communal facilities (eg. residents lounge) and personal care. Personal care, according to home Life[2], is 'care which includes assistance with bodily functions where such assistance is required'. The precise boundary between a residential home and a nursing home is a subject for interpretation by the health and local authorities who are responsible for registering homes under the Act. In recent years local authority provision of Part III accommodation for the elderly has grown only slowly. In 1984, it amounted to about 116,000 places in England. Provision of residential homes by voluntary bodies has also increased slowly from about 35,000 places in 1980 to 38,000 places in 1984 in England. In contrast, provision by the private sector has increased at a fast rate. In England there were about 32,000 places in private homes in 1979 but by December 1984 there were an estimated 77,000 places; this represents an increase of about 140% in just under five years. Growth in Scotland has been at a slower rate.

Further growth now appears unlikely in the main urban areas because of high property value. Many of the established coastal retirement areas have, or appear likely to have, an excess of supply; new homes, though, continue to open despite this situation. The pattern of growth is also sensitive, of course, to the level at which the DHSS supplementary benefit limit for residential homes is set. At present, then, the market is in a state of transition. With regard to the level of dependency of clients, local authority Part III homes and private homes have different approaches to assessment. Whereas local authorities almost always assess their clients need for residential care, such an assessment of needs in the private sector is an exception. The survey shows that the dependence of residents is marginally lower in voluntary homes than in private homes.

The Registered Homes Act (1984)

The Act came into force on 1 January 1985 and introduced regulations, comparable to those in existence for nursing homes, to control all residential care homes. Nursing and rest homes were brought under the same legislative roof, providing new substantive and procedural controls. The Act was based on an accreditation model and prescribed minimal statutory standards with sanctions of de-registration and prosecution. Separate codes of conduct and advisory norms were published for nursing and rest homes to encourage higher standards. Registration became necessary if a minimum of four people were being cared for. Dual registration became obligatory if four or more residents in a nursing home received personal care rather than nursing care; and if one or more residents in a rest home received nursing care. Dual registration required that both health and local authority registration officers inspect the home and register it as complying with their regulations.

The provision for dual registration was to enable the residents to continue to be cared for, without a break, in the same premises when their medical condition improved or deteriorated. While the level of care in the two kinds of home can 'shade' together, the fundamental difference is that a nursing home is required to provide nursing care of a kind and such an extent (in numbers of nurses) as the registering authority considers appropriate. What this means is that the whole of a home which provides both nursing and personal care will be dual registered, but the two aspects of care may be given separately (in separate parts of the building) or together (in a residents own room).

Conclusion

There has been a significant growth in private sector provision for the care of elderly people over the past decade. The increase has been greater for residential homes than for nursing homes. A number of factors have stimulated this growth including an increase in the elderly population, a greater emphasis on treatment at home in the public sector, and a politically favourable climate for private sector development. The

Registered Homes Act (1984) in formalising the difference between nursing care and personal care, has left a host of problems associated with dual registration, and has highlighted existing problems in private sector care.

* * * * * * * *

THE CONFERENCE PRESENTATIONS

The ensuing presentations represent the views of different statutory and private agencies; the overall attempt is to:

1. outline the issues in registration

2. discuss local efforts to overcome problems and

3. provide examples of good practice

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CHAPTER 2 - VIEWS FROM THE PRIVATE SECTOR

'THE REGISTERED HOMES ACT 1984' - A VIEW OF THE EXPERIENCES SO FAR FROM THOSE INSPECTED

Dr Patrick Carr, General Secretary of the Registered Nursing Homes Association gave the following paper which is reprinted in full.

The introduction of the 'Registered Homes Act 1984' was welcomed by most nursing homes in the U.K. who wished to see residents looked after to a reasonable standard. Due to the nature of the nursing home business and the wide ranging cover of the Act, it was recognised from an early stage that the major success or failure of the legislation would depend not so much on the 'Registered Homes Act 1984' but on the interpretation of local rules and regulations by the registering authorities.

One of the major complaints of nursing homes prior to the introduction of the Act was the wide ranging interpretation of rules and regulations implemented by different authorities and so it was felt to be a major step forward when the National Association of Health Authorities (NAHA) introduced a national set of Guidelines[3] for registering authorities to use in establishing their local rules and regulations. The RNHA felt that the introduction of these 'Guidelines' would make a major effect on the ridiculous situation of homes one mile apart but covered by different health authorities having running costs ranging from £70.00 up to £250.00 because of the standards demanded by the local inspecting officers.

The View of Nursing Home Owners in 1986

1985 proved to be a year of exceptional activity by health authorities in producing local guidelines. Some health authorities held extensive consultations with nursing home proprietors in an effort to produce local guidelines which would benefit the patient in the view of both the health authority and the nursing home proprietors. Other health authorities felt that the only people able to draw up such rules and regulations were health authority officials who may or may not have had past experience of inspection of nursing homes.

Some health authorities took a great deal of notice of the N.A.H.A. Guidelines and used them as a basis for their own guidelines. Others spent considerable time in amalgamating their own views with views of the N.A.H.A. Guidelines that they felt relevant and a further group do not appear to have read the Guidelines at all.

Nursing home proprietors during the year of 1985 were in a state of limbo contradictory statements when attempting to obtain information on the likely requirements of health authorities. Some inspecting officers implemented their own strongly held beliefs on various aspects of nursing care and demanded introduction of varying standards. If there was something a nursing officer felt strongly about, then she would demand that it be implemented, whereas other aspects of care that she may not have covered extensively or did not feel strongly about, would be ignored.

To sum up 1985 in one single statement is probably best achieved by saying, 'Chaos reigned supreme'.

Costs of Registration

1985 also saw a report by the health authorities for the Government on the amount of income obtained from nursing homes to pay for the services expected by the health authorities to complete the various procedures of registration. As a result of the returns provided for a year which was generally accepted as being exceptional in the extra amount of work covered by health authorities in the implementation of new guidelines, a vastly increased set of registration fees was introduced for 1986.

It is quite obvious from the lack of increase in health authority activity in the area of nursing homes that this income is quite unjustifiable from the point of view of the nursing home owner and has just proved a different means of subsidising the Health Service by Government. The amounts of money involved may be small from the health authority's point of view, but they are a further drain on top of the many other drains introduced in the last three years on nursing home income.

It is the view of most nursing home owners that the 'Review of the Costs incurred by Health Authorities in the Registration and Inspection of Private Nursing Homes' Report[4] was based on speculative information and relied too much on individual interpretation of costs rather than actual fact, and so cannot be relied on as accurate information.

Some of the most up-to-date information on nursing homes has been gathered by the University of Bath, Centre for the Analysis of Social Policy. Their introductory statement in Paper Number 9, 'Pricing the Nursing home Industry: Capital and Turnover'(5) is perhaps also relevant concerning the costs to the NHS of inspection of nursing homes:

> 'Despite the debate provoked by the growth of the nursing home industry, remarkably little is known about it. There is no routinely collected, systematic information about the consumers of the services provided by the nursing home industry; the only available information comes from special surveys (Bartlett and Challis 1985). There is no systematic information about the providers of the service, apart from the somewhat inadequate data routinely collected by the Department of Health and Social Security on Nursing Manpower (Day and Lada, 1986). Even the most comprehensive profile of the industry yet drawn up (Laing and Buisson, 1985) of necessity has to rely on very broad estimates and so leaves gaps.'

It would be the view of nursing home owners that this statement can be accurately extended to cover the amount of information available on health authority involvement in Nursing homes.

Rules and Regulations vs. Quality

It is perhaps relevant at this stage to quote from the introduction of the NAHA Handbook(6) under Quality of Care, (Section 1.3 a), 'For all long stay patients, the Handbook stresses the importance of flexibility and individual care. It recommends that patients be provided with a lifestyle as 'non-institutionalised as it is possible to provide'.

It would appear that most health authorities have put great stress on the introduction of rules and regulations which are inflexible and they expect all nursing homes in an area to conform to the requirements laid down in their Guidelines, ie. 120 sq. ft. of room space or five nurses on duty in the day, of which one third will be qualified, etc.. The great reliance of health authority inspecting officers on rules and regulations as being the only means of completing their job has in the opinion of many nursing home owners defeated one of the prime objectives set by the 'Guidelines'.

Section 1.3.b., 'For elderly people, the Handbook puts stress on flexibility and sensitivity to their changing needs. The Handbook recommends regular occupational and leisure activities to be available and visiting arrangements to be flexible.'

Again the adherence of inspecting officers to the 'rules and regulations' as opposed to assessing each individual home on its merits, would seem to defeat the aims of flexibility and sensitivity and certainly hampers the introduction of individualised occupational and leisure activity as required by the patient. Paragraph 1.4. of the Guidelines states, 'At all times, the working party has had in mind that all patients in nursing homes should be treated well; should live in decent conditions; should be encouraged to be as independent as possible and should have their self respect preserved. All those concerned with nursing homes, whether they be proprietors, staff or inspecting officers have a duty to keep this consideration uppermost in their mind'.

Again a massive overemphasis on rules and regulations defeat many of these objectives and it would appear that the majority of the inspecting officers are primarily basing their interpretation of rules and regulations on the way they have done things in Hospitals and the procedures undertaken on wards and in ward situations for the good of patients. The individual needs of each patient are totally ignored in an effort to achieve a common denominator that can be applied to all nursing homes.

Most nursing home owners believe that a simple question should be asked about all rules and regulations, namely,

'IN WHAT WAY WILL THE PATIENT BENEFIT BY THE INTRODUCTION OF SUCH A RULE OR REGULATION?'

It is the experience of nursing home owners that very few inspecting officers or health authority personnel ask this question in relation to nursing homes and their operations. Indeed, many of the 'regimes' forced into being by local rules and regulations seem to be more closely related to the past than aims stated for the future.

Most experts today feel that the move to community nursing is important and one of the major aspects of such forms of care is the transition to individual patient care from institutional patient care. All home owners recognise that the establishment of any home is bound to establish a form of institution, but allowing the widest possible choice of homes in an area, whilst conforming to basic standards of good care, provides a way for optimum individual care to be available in that community.

Every registered nurse has a different set of priorities and this is not necessarily a bad thing. By allowing these nurses to implement their own set of priorities, different types of approaches will create different types of home, so providing an extensive choice which is likely to succeed in satisfying the varying expectations of patients and their relatives in each area.

All patients and their families have different priorities when looking for nursing care; by introducing single sets of rules and regulations, average standards throughout the area may be achieved, but at the expense of individual needs.

Prior to registration of a nursing home, the people responsible for the operation of the home are extensively investigated. The N.H.S. Management Services Report 10/85 states that one of the responsibilities of a district health authority is to establish the fitness of the applicant to run the home and both financial and professional references are taken up and satisfaction attained as to the nursing abilities of the qualified nurse in charge. Nurses are trained for a minimum of three years and most nursing homes' senior qualified nursing staff have many years Health Service experience. They undertake considerable risks, both from a financial and a professional point of view in accepting senior posts in a nursing home, whether as proprietors or as employees. If inspecting officers feel it necessary to put such individuals in a straightjacket of rules and regulations, when allowing them to operate, they do not understand the attributes necessary in those seeking to establish or run homes.

It would appear sensible that when inspecting officers enter a home which appears to have problems, they should try to identify these problems. However, when entering a home that appears to be well run, then it would be better to identify the reasons for success. Yet, it is widely experienced by nursing home proprietors that inspecting officers will say, 'Yes, you have a super home, your patients are well cared for, but our regulations say that you must have another qualified nurse on in the morning, and at night and you must build a new lounge and increase the size of your kitchen by 2 sq. yds. because our regulations say so'.

Put in this way, the statement appears ridiculous but nursing home owners will confidently tell you that every inspecting officer has been guilty of this statement in some form or another

With the establishment of the 1984 Act and N.A.H.A. Guidelines, Nursing home proprietors hoped that basic standards of care expected by health authorities would be standardised throughout the country, as opposed to past experiences of poor standards being acceptable in some areas, whereas highly restrictive and expensive regimes dominate others. The survey of Private and Voluntary Residential and Nursing Homes for the DHSS undertaken by Ernst & Whinney states in paragraph 160, 'It is clear that there are some major differences in policy on matters such as the maximum size of home, room sharing, staff levels, the number of baths and toilets and the installation of lifts. There are also differences in the authorities' requirements as to when necessary improvements in premises are to be completed', and 161, 'These differences in registration requirements have some effect on the operation of the market, in that new homes are discouraged in areas where the requirements are stringent. These differences in registration requirements can also be expected to have a significant effect on the unit costs of providing nursing home services in some areas, particularly variations in room sharing and staffing levels'.

This independent report in May 1986 shows that the old story of vastly differing standards still exist. This is confirmed by the experience of the inspecting officers of the RNHA who turn down approximately 10% of applications for membership of the Association because the standards of the homes inspected do not achieve acceptable levels for reasonable care.

Ironically, some of the lowest standards of care have been found to exist in areas where the rules and regulations seem excessive to nursing home owners in general - it appears that the inspecting officers in these areas are spending too much time adhering to the 'book' and not enough time looking at the condition of patients! Further proof of variants in standards may be seen from reports in newspapers and from television programes such as the 'World in Action' documentary broadcast in the Spring of 1986.

Conclusions

When the 1984 Act and the N.A.H.A. Guidelines were introduced many nursing home proprietors felt that the documents were very encouraging and that major advances could be achieved if the implementation were successful. However, many health authority inspecting officers still adhere to their own standards and policies on nursing care rather than assessing the needs of individual patients in individual homes. In the opinion of nursing home owners, the only way to implement reasonable standards at an economic cost would be the establishment of an independent nursing home inspectorate, either directly responsible to the D.H.S.S. or to regional health authorities. The major basic requirement of these inspecting officers would be a first level nursing qualification and medical, administrative and social work qualifications should be seen as an unsatisfactory background for such a position. The nurses appointed should then undergo a training programme agreed by the health authorities and the RNHA with input from both groups. The N.A.H.A. Guidelines should be accepted as the recognised guidelines for all nursing homes in the U.K. and variants either above or below these set standards should only be because the patient benefits from such variants.

The two statements already made, namely:-

'In what way will the patient benefit from this rule?', and 'This home is a good home - in what way can I learn from its operation?' should be the fundamentals of such inspecting officer training if individual patient care is ever to be improved.

These trained inspecting officers should be able to take advice from:

a) Community physicians, geriatricians and other medical experts.
b) Health authority administrators.
c) Health authority pharmacists.
d) Fire officers.
e) Environmental and health and safety officers
f) Building inspectors and planning officers
g) Primary health care teams
h) The United Kingdom Central Council (U.K.C.C.) and Royal College of Nursing (R.C.N.)

..... and any other experts who may be able to advise on specialist situations. However, these consultations should only be necessary as exceptions, the training given to the inspecting officers should cover all the normal procedures expected to be known by nursing home proprietors.

It would seem that the introduction of a professional team of well trained inspecting officers would be the basis for the future development of one overall group of residential homes. The implementation of an accreditation system for the improvement of efficient use of taxpayers' money, nursing home working conditions and, most of all, the standard and wider implementation of individual nursing care, would be an essential development of the work of such a team. Rules and regulations in themselves only implement standards - 'good care' can only result from commitment from the individuals completing the tasks.

* * * * * * * *

THE VIEW OF RESIDENTIAL HOME OWNERS IN 1986

Mr Chris Beddoe is the **Director of the National Confederation of Registered Rest Homes Association, (NCRRHA);** the following is based on his presentation.

Mr Beddoe, with reference to the 1984 Act, made the perhaps forgotten point that this was a major piece of consumer legislation. The positive implications of the Act have been to strengthen inspections, to force owners into greater consideration of care standards, and to promote a major debate about what is social and what is nursing care. It is important to note that, enshrined in dual registration, is the notion of continuity of care, and indeed home owners on the whole have a positive commitment to the 'least moves' principle. However, this important issue of continuity of care could become somewhat confused and lost in the greater confusion of the enactment of dual registration. Mr Beddoe emphasised the provision of a client-centred service. He noted the practical difficulties in defining residents care needs, and mentioned the role of the GP in helping to assess medical, psychological and social needs on an individual basis. Indeed, the GP and primary health team are often not accorded much prominence in these discussions when, in practice, they are important members of the overall team providing care for residents.

How then are residents needs to be met? In a residential care home three major types of service can be defined:

1. Social Care; this is the type of care that could be expected to be given by family members to their relatives. Care staff within residential homes undertake to provide this service for their residents.

2. Community health care services; these are the primary health care team including the GP and the district nurse, who offer services to people in their own homes and also to residents when in residential homes.

3. In-home medical care; if a residents medical condition indicates that 24-hour nursing care is required, it is the home's responsibility to ensure that the skill and the facilities are available which require the home to be dually registered. This raises the interesting point of whether the distinction between nursing homes and residential homes will become a thing of the past, and a new type of home develop offering all forms of care. Mr Beddoe though, was at odds to point out that dual registration should not destroy either nursing homes or residential homes, but should enhance the care offered by all homes in the private sector.

With regards to dual registration there is the danger of creating artificial difficulties, that is:

1) difficulties due to professional rivalry between health and social services

2) the need for each agency to retain administrative autonomy

3) difference in philosphy of care.

These are real difficulties for the agencies and individuals concerned, they are not difficulties that arise necessarily out of the Act itself. In the experience of the NCRRHA it was felt that registration officers are preoccupied with the physical aspects of a home rather than the quality of care being offered. This was felt to be because no nationally accepted philosophy of care had been fully developed. Thinking had developed in a way that was agency specific (i.e. rooted in the health services or social services), and most registration officers were therefore, 'swimming in the dark' when faced with different ways of working and different principles determining the running of a home.

We are now two year's on from the Act and this issue of consistency is becoming more pressing. Laing and Buisson in conjunction with the NCRRHA have analysed the local authority guidelines and predict huge variations. There is growing conflict and confusion around the role of 'policing' responsibilities. People want to see an inspector/registration officer and a befriender/advisor/supporter. The two roles can quickly become incompatible, and perhaps we need to see different people performing these different functions.

The issue of cross-sector comparability has become more prominent with unfavourable comparisons of local authority homes against the private sector it may be that the growing public awareness of this situation will help break down the sector barriers in care and initiate guidelines across all residential care.

In conclusion, we are in a phase of social change. There is no national consensus on what constitutes quality of life and, as physical requirements become standardised, the national debate needs to shift and focus on this issue. We need a range of philosophies of care to stimulate people to be flexible and experiment with care practices. Most importantly, this social policy should be pushed forward today, even if controversial, to produce creative and innovative care tomorrow.

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CHAPTER 3 - DUAL REGISTRATION: A LOCAL AUTHORITY'S PERSPECTIVE

Mr George Small, Divisional Inspector of Private and Voluntary Homes expressed the following views from social services perspective, reflecting the work of his department in **East Sussex, Social Services.**

The major emphasis in "home Life" is to provide a service sensitive to the individual changing needs of clients; within this context dual registration is welcomed. However, there are practical difficulties for all concerned, as registration officers have had as yet, little experience of the practice of dual registering a home. East Sussex is fully committed to the view that unskilled social care and inappropriate nursing care both create dependence. It is important then, that care is aimed at facilitating the maximum potential from each individual resident. This basic principle of care can be served by the process of dual registration.

It is important for homes to create as domestic a lifestyle as possible, based on the residents wishes and needs, although with realization that commercial viability is also a consideration in the owners mind. However, residents have a right to demand that their personal lifestyles are preserved and developed. This means the home should reflect the positive aspects of 'being home'. Residents, for example, should handle their medication and have tea making facilities freely available if at all possible. Residents should not be moved around the building or elsewhere without a great deal of prior consideration; bedrooms should be 'ones own' unless extreme circumstances intervene. Residents are entitled to a basic level of care and treatment in a residential home, and are also entitled to the full range of National Health Services including district nursing services. Doctors may delegate treatment to care staff that a relative would be required to perform.

Incontinence and confusion are often cited by owners of homes as reasons for moving a resident elsewhere, or restricting their environment within the home. East Sussex, like other authorities, does not automatically accept these two factors as being valid reasons for moving residents out of

their familiar environment. Residents rarely become incontinent for no reason, and it is the responsibility of the home, the GP and other relevant professionals to get together and sort the problem out. For example, it may be that the resident has a urinary infection, their clothing may be tight and difficult to remove when going to the toilet, they may sit a long way from the toilet and may only be getting attention from staff when actually incontinent, all these reasons and more need to be explored. Equally if a resident is confused, this should always be actively investigated, and not just assumed that 'it's because of their age'. Staff in homes have a duty to ensure that a medical assessment is sought. Sometimes the staff may need to act as advocate for the resident in ensuring they receive a thorough and comprehensive assessment. The role of a registration officer is to support staff in this task and suggest alternative courses of action. Even if a resident's confusion is untreatable, there are many simple steps that a home can take to help themselves and the person concerned. The staff and registration officer should approach the problem in a constructive working manner, obtaining professional advice if necessary.

The ordinary human rights that residents can demand in a home have many implications for its management and registration. The 'least moves' principal means, as already stated, that residents should not be moved around unnecessarily. East Sussex Social Services has agreed a policy with their Health Authorities whereby a room, a person, fixed numbers of people, a wing of a building, a whole building may be dual registered. Dual Registration then, in allowing nursing care to be delivered within the persons own room goes a long way towards supporting this principal. If used flexibly and creatively the Act can do much to ensure quality of life for all residents.

Joint Health and Local Authority Forums

There are however, major areas of potential conflict in dual registration. Different agencies have different policies and perspectives. There are different views on social care, nursing care, dependence level, registration categories, etc. There is the problem of different physical requirements, such as room space, day facilities, fire precautions, size and location of

homes. There are also different staffing concerns, especially on such issues such as night cover and styles of care. The multiplicity of problems have threatened to overwhelm the benefits of the Act, and whereas they will not be resolved quickly, the framework and process for working on these problems should be a priority development for health and local authorities.

The problems that arise in dual registering a home have been tackled in East Sussex by forming a joint health and local authority forum, which negotiated various guidelines for dual registration. Firstly, in residential homes there must always be a named person accountable for nursing care - not necessarily the manager. The forum has worked out a set of joint standards for the physical requirements, such as lounge and dining room space in all homes. Bedrooms in nursing homes should meet local authority standards. The higher standard of fire precaution should prevail within each home. Staffing issues should also be negotiated jointly for each individual home.

Secondly, the forum agreed upon various administrative procedures. Either agency receiving a request for dual registration automatically informs the other authority. Joint visits are arranged to the homes, all reports are discussed and agreed by both authorities, prior to presentation. The agency registering the most beds has the key coordinating role. There is a minimum of two joint visits a year with a joint report, individual reports are also shared. The joint visit is arranged at the time of registration. Health authorities routinely inform the local authorities when new nursing homes are approved. The normal procedure of appeal applies to dual registered homes; the agency receiving a complaint will acknowledge and communicate with the other authority, and a joint decision will be made as to who should investigate. Every attempt is made to minimise bureaucracy and synchronize work wherever possible.

Continuous discussion is required on what is good social and nursing care, and it is every officer's responsibility to ensure that the debate continues. Obviously problems still arise, but this model of joint working goes a long way to providing both the framework and the mutual trust essential to finding solutions.

Ongoing issues for the forum are likely to centre around staffing issues, the monitoring and updating of registration categories, joint inspections and the use and availability of community resources. Future changes though, should be dictated by the overriding consideration of providing the best care for individual residents. This can only be achieved through the cooperation of health and local authority officers and owners and staff of homes.

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GOOD PRACTICE IN NURSING HOMES

The following section consists of a presentation describing specific examples of good practice in **Southport and Formby.** They are presented so as to share current experience on ideas that have worked well, and to stimulate other authorities and homes to think about similar local schemes. They are not intended as a blueprint for local action but as a starting point for discussion.

Finally in this section there is a brief look at home brochures. This topic was not covered formally in the conference but did arise at various points throughout the day. The ideas discussed have been bought under a single heading, and have been included as a further example of good practice.

Miss Alison Philips, Registration Officer from **Southport and Formby Health Authority** described the following examples of good practice that currently exist in her district.

1. The Sefton Registration Pack

This pack contains the dual registration requirements of the health authority and the social services. It is the result of a joint working party of health and local authority staff, experts were invited where appropriate to give advice about particular specialist areas. The information contained in the pack is therefore both comprehensive and practical.

The registration requirements have been standardized so as to make dual registration an easier matter. Also, with the help of pharmacists, a standardized medication sheet has been produced for use in both nursing and residential homes. The pack contains three application forms, one to register as a residential home, one as a nursing home, and one for the matron/person in charge. (East Sussex Services also produces an information pack for prospective home owners).

2. Matrons Interview

The matron/person in charge is interviewed separately from the owner of the home, to discuss nursing standards and requirements. This is a formal interview with references being taken up; the person is also checked out with the UKCC. If the matron/person in charge is also the owner then two separate interviews are held each with a different emphasis and purpose. A programme is arranged through the in-service training officer according to the needs of a specific matron, and may include time in geriatric wards, physiotherapy, occupational therapy, pharmacy or the community services. The matron is informed about the nature of the inspection reports by the registering officer, and that inspections generally occur without warning. Potential areas of improvement within the home are also discussed at these initial stages. Miss Philips feels that this interview lays the foundation for the future working relationship, and is essential so as to establish an open honest approach from both sides right at the start. There is also a medical note from the matron's GP, stating that Mr or Mrs X is medically suitable to be in charge of a nursing home.

3. Matron/Owners Meetings

These meetings are held at the post-graduate medical centre on alternative months. Their purpose is to provide a forum for the interchange of information and views. Speakers are invited, (not representatives from companies), and the atmosphere is informal but progressive. As a result of a lecture by the environmental health officer a series of lectures were set up at the local technical college on food hygiene, cook chill methods etc, (an examination was set and certificate awarded to all successful participants). Further visits were arranged after the fire officers talk. It was discovered that the group members had never seen a fire and were concerned how they would react, they were given the opportunity to attend the Fire Brigade Headquarters to experience and put out every type of fire likely to occur within a home, under controlled conditions.

Social Service Officers came to talk about dual registration from their point of view, and, as a result of this meeting, joint guidelines have been produced on suitable clientele for residential homes. Discussions at one meeting highlighted a weakness in communication between hospital and nursing homes, leading to a regular meeting with the director of nursing services, nursing officers and sisters, and five matrons representing nursing homes. The meeting also gives support to new matrons or owners, and is used as a basis for arranging visits by owners and matrons to other homes.

The function then, of the Matron/Owners meeting is to encourage and debate what is good practice both in individual homes and across the district.

4. Bed Bureau

The Bed Bureau was set up following requests from professionals who were frustrated in obtaining beds in homes. It also saves frustration for elderly people and relatives who can get desperate and exhausted when looking for a vacancy in a home.

The bureau works by the homes phoning in with their vacancies (and phoning again to cancel), the onus is upon them to provide the correct information. The information that is passed onto enquirers is descriptive only (eg. 'one female sharing on the ground floor'). No home is recommended and no prices are given, it is up to the applicant to seek this information from the home. This service indicates to registration officers when a home is frequently carrying vacancies, and raises the question 'Why?'. The bureau also provides information on wider issues such as whether the market is being saturated, or whether there is room for further private development within the locality.

The bed bureau is very simple to set up, it requires one board, one pen, and one person at the end of the phone. The success of the bureau in Southport and Formby, indicates the advisability of setting up this scheme elsewhere.

5. Education

All nurses have a responsibility to keep themselves updated on new information coming into the field. The matron's meeting provides a major educational input for individuals, as does the initial interview with the matron.. However, other training needs often remain unmet. In Southport and Formby, with the approval of the director of nurse education and the nursing officer for in-service training, this problem was tackled by courses and lectures being made available at the local nurse training school. To date there has been no charge for this service. The arrangement has also resulted in training for care assistants from residential homes on an ESMI ward/unit; and, if there are vacancies, the chance for them to join educational events held for the nursing staff at the hospital.

6. Quality of Care

Even with a nice building and every regulation adhered to, there is no quality of life for the residents if it is not 'a good home'. Good quality of care means surroundings that suit individual tastes, warmth, good and kind attention, courtesy of staff, companionship, privacy, likes and dislikes remembered, birthdays and special days remembered. Residents, like all of us, need a reason to get up in the morning to have something to plan for, think about, bring a thrill in the day, something to stir memories. The following suggestions are in operation in Southport and Formby:

(a) A family meal day for one resident at a time, as a monthly event. This means setting the private table in the resident's own room, providing a meal for his/her visitors (including the grand-daughter and the dog), and leaving them to have their meal without interruption. Clearly residents should be fully involved in the preparation of the event. This makes visiting more enjoyable and normal for both relatives and the resident.

(b) Most homes arrange outings for their residents, but how many owners/matrons find out their residents interest and follow them up, for example with a visit to a football game, the dogs, the races or a pub.

(c) People tend to think that elderly people like to shop at Christmas, but elderly people like to shop at anytime! Shops which open late especially for the disabled at Christmas are now doing so for Easter and at other times. A bit of investigative work and liaison with shop owners can be very helpful if residents do need special access. However, this special arrangement should be the exception rather than the rule, as most elderly people in homes can go shopping either on their own or with staff during shopping hours.

(d) For residents who receive visitors, if they are able when their visitors are due, do they answer the door to greet them, and be there to wave them goodbye, as they would in their own home?

(e) How are residents helped to retain the skills they possess prior to admission? One way of doing this is by not removing everyday tasks to somewhere out of sight. For example, ironing could be done, with safety precautions, in the lounge, giving the staff member doing the ironing an opportunity to chat to people present. Other daily tasks such as mending and sewing could be done with, and by the residents.

(f) How much imagination is given to try to solve difficult problems? The example was given of a confused eighty-five year old lady who tended to wander out of the nursing home and down the street. Being near a main road there was clearly a danger, but she did not want to be moved to more secure premises. A bit of imagination and creative thinking came up with the solution of a device tag used in shops - a local firm produced one - the tag fits under the dress out of sight and sets a buzzer off when the person walks through the front door. This activates staff who join her for a walk and can ensure she returns safely home.

7. Meeting with other Agencies

Southport and Formby have recently formed a residential homes joint co-ordinating committee which meets formally on a regular basis with social service staff and health authority staff within Formby and the neighbouring districts. Each agency takes it in turn to host and chair the meeting and provide the agenda. This practice has done much to improve links between agencies and across district boundaries.

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These examples of good practice in Southport and Formby provide a model to inform other authorities and homes. The development of these practices have occured through the commitment of the registration officers to building up good relationships between the different agencies, and the realisation that quality of care for residents can only be achieved in an atmosphere of co-operation.

Finally in this section home brochures are discussed as a further example of good practice.

A Home Brochure

A 'Home Life' advocates that all homes should write a brochure or prospectus stating 'the degree of care offered, the extent to which illness or disabilities can be accommodated and any restrictions relating to age, sex, religion etc. The brochure should actually describe facilities, staffing and accommodation offered, and may include terms and conditions'. It goes on to say of residential homes that 'while limited nursing may be made available to residents, and references to this may be in the brochure, the proprietor must not imply that the establishment is a nursing home'. If in doubt, reference should be made to the registration authority as to what statement is permissable and to ascertain whether dual registration is required. East Sussex Social Services information pack recommends that when writing a brochure owners think themselves into the residents shoes by imagining what their own requirements would be when considering residential care, and that this should give good pointers as to what might be included.

The brochure should also contain the clearly stated aims and objectives of the home. These aims may be, for example, to provide a homely environment for the residents, another aim may be to ensure residents retain individuality and dignity. In East Sussex, the Social Services use the stated aims and objectives outlined in the brochure to partly serve as a monitor for the actual services offered by the home. Other information that should be included in the brochure are such things as the level of fees, time and method of payment, services covered by fees, extra services which are charged separately, the procedure for increasing fees, and so on. 'Home Life' provides a comprehensive list of the terms and conditions that should be covered.

'Living in Homes; a consumer guide of old people homes'[7], is an excellent guide for elderly people contemplating a move into sheltered housing or a residential/nursing home. It provides basic information about the running of homes, and also poses many questions that people may like to consider before moving into a particular home. Owners of homes who are writing a brochure may like to take into consideration the issues and questions raised in this book. Research undertaken at the University of Bath[8] looked at providing homes with a standard format that could be used when producing brochures. This format included comments from lay people in the community on their feeling about the establishments. homes were described as having a 'homely atmosphere' or being 'business like' - this subjective assessment by ordinary people was felt to be extremely helpful for potential residents when making their choice.

The Elderly Accommodation Council[9] has just launched a national computerised register which contains information about sheltered housing, hospices and residential hotels as well as residential care homes and nursing homes. Proprietors pay an annual fee of £15 to appear on the register, elderly people pay £6 for a computer printout of facilities available in their area. It is left to them to make the initial contacts with homes and to inspect them.

Brochures can be an invaluable aid for elderly people contemplating entering a home. However, they are not in themselves sufficient means to regulate standards. Information has to be readily accessable and easily understood, but even then there will be elderly people who, because of their mental state, would not be able to effectively use the information. Also, if elderly people are to make an informed choice from the information given in the brochure, and to know whether they will be receiving value for money, they would need to know what actually goes on in the home, and compare with the claims which are made in the brochure. This is clearly difficult to achieve. A brochure then, should not be assumed to safeguard consumer satisfaction.

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CHAPTER 4 DISCUSSION GROUP SUMMARIES

The conference run in **1981** by the King's Fund[10] on private and voluntary residential homes for elderly people covered the following topics in discussion groups:

1. **The nature and purpose of care.**

   The need for a thorough assessment of all residents admitted to homes was emphasised. The role of nursing care was felt to be to achieve a balance between the social and psychological needs and the physical and medical needs of residents, the need for the community as a whole to understand the nature of care for old people was also stressed.

2. **Professional support.**

   Local authorities should make the professional advice of their specialised staff, architects, planners, environmental health officers, available to proprietors and staff of homes. Inspectors should be obliged to write constructive reports following their official visit to homes so as to enable staff to self-evaluate their service. The support needs of owners and staff of homes, and Inspectors was also discussed.

3. **The relations with statutory authorities.**

   The points raised were mainly practical ones such as the bulk buying of furniture, equipment and food, and the pooling of relief staff available to work in health authority and private homes. It was suggested that grants may be made available through local authorities for specialist equipment and for innovations in care facilities. It was proposed that a liason committee should be set up in each local area to include representatives of the fire department, the local authority and home proprietors and staff.

4. **Training.**

Provision should be made available for training both on and off the work place. Training schemes should be introduced for voluntary workers in homes, and all training should be shared jointly with local authorities and health authorities. The staff of homes should be made aware of the work of other professionals working with elderly people.

In summary the points discussed in 1981 would appear to be concerned with the actual service being offered to residents, and the local factors affecting individual homes. The comments were about practical issues such as the use of local authority professional staff, the role of assessment in private homes, bulk buying of furniture, and so on. In contrast, the discussion groups in the 1986 conference, tended to focus on more general across-the-board issues such as the definition of nursing and personal care, a national inspectorate and national training body. However, there were considerable areas of overlap, especially in discussions on definitions of care. The shift in emphasis from local to national issues probably reflects the impact of the 1984 Act in highlighting the process of registration and the differing functions of nursing and residential homes.

The discussions in the small group sessions covered the following themes:

1. **Conference Participants Experience of Dual Registration**

Dual registration was described by one conference participant as 'not so much a grey area, but a thick fog'. Professional rivalry between officers of local and health authorities emerged as a serious source of conflict to the extent, in some cases, that the two registering officers did not communicate - a real problem when attempting dual registration! home owners generally appreciated that coming to terms with two masters was difficult enough, but, where the two masters were in conflict then the whole recipe was disastrous. It was felt to be of paramount importance that both local and health authorities present a professional joint approach to the home owner,

and that the two agencies look closely at their differences and, where necessary, compromise so that clear guidelines can be jointly agreed.

There are also difficulties when applying the definition of nursing and residential care. How, for example, will a proprietor, or an inspector, determine whether a resident in their room is receiving nursing care or personal care. The legislation was introduced in the acknowledgement that residents do not conform to legislative compartments and that the differences between 'nursing care' and 'personal care' was often difficult to establish. Yet, under the new Act, homes are required to keep a daily record showing the type of care given to each person. This highlights the distinction between different types of care, and provides inspectors with the almost impossible task in their annual, or more frequent visits, of determining whether homes are offering the care which appears on the daily record. Further complications may occur in that residential homes have to be dually registered when one or more residents require nursing care, but for nursing homes, dual registration is only necessary when four or more persons require personal care. This can lead to frequent visits, especially to residential homes. Registration officers from both health and social services who are already overworked and overstretched now also have to inspect homes whom they suspect of offering care for which they are not registered. The workload may become unmanageable.

Dual registration clearly requires considerable effort by registration officers to work collaboratively and cooperatively - but what if they don't? If they cannot agree on standards and regulations, who will have the final say and how much effort will be invested in trying to find a compromise? Finally, one of the major problems noted by participants was the problem of registration categories having to constantly change due to fluctuations within the client group. This could lead to a home requiring many joint visits within a short period of time.

The experience of dual registration, since its introduction on the 1st January, 1985, has been one of confusion more often than harmony and benefit. The experience has highlighted clearly the need for a national inspectorate to establish overall standards.

2. The Establishment of National Guidelines

There was much discussion in the groups about the differing standards that applied across the country. Different standards were noted not only between local and health authorities in a single district (eg. over room size) but also amongst different social services departments and health authorities. Flexibility is clearly vital to maintain a responsive service for residents. However, the inequalities in standards across the country was the cause of much dissatisfaction and frustration for registration officers and owners of homes. This situation highlighted the need for National Guidelines with a corresponding move towards regional inspections. However, the point was made, particularly by Doctor Carr, that guidelines in themselves are advisory and not mandatory.

One of the most pressing needs is for a national or regional inspectorate, to establish norms for the physical standards of homes which would take into account the Dual Registration Act. One of the greatest advantages of having a standard room size in residential homes and nursing homes, is that residents will be able to stay in their own rooms when at the stage of requiring nursing care, so helping to provide continuity of care. A national inspectorate would not, of course, just be concerned with imposing common physical standards, but also encouraging and facilitating good quality of care in all homes. Despite the different functions of residential and nursing homes, there are certain principles that apply across the board when caring for elderly people. These are principles such as maintaining maximum independence for residents, respecting privacy, living in decent conditions, and so on. These principles, espoused in home Life, should be maintained by a national body. A national inspectorate could also cover functions such as training (discussed below).

The composition of a national inspectorate was discussed. It was felt that there should be representation of both private and voluntary homes, voluntary organisations involved directly in the care of elderly people, and those involved at other levels, for example, Age Concern, Centre for Policy on Ageing, Centre for Environmental and Social Studies in Ageing, and so on. It was not clear whether the latter agencies would play a direct role in the Inspectorate, or be advisors to the body.

3. Definitions of Care

There was much concern voiced throughout the conference at the definitions of nursing care and personal care. The Act specifies that 'personal care means care which includes assistance with bodily functions where such assistance is required;....'[11]. The House of Lords recently decided that the interpretation of this definition implied a 'high degree of physical care and was directed at the functions a fit person normally did for him or herself, but where attention or assistance were now required'.

As Carson[12] notes what this means in practice is that inspecting officers must assess for that which ought to be provided, not for what actually is, or is not, provided. The Act offers no help on the definitions of nursing care. Participants felt that this was the one issue causing greatest controversy and disagreement, with even individual health authorities unable to agree amongst themselves. Care of open wounds, drug administration, bed sores, terminal care were some of the contentious issues raised, with some health authorities requiring the services of a qualified professional nurse for these tasks and others accepting the community nursing service. There was some discussion as to whether it would even be seen as illegal for a residential home to keep someone until death.

There was some agreement that the difference between the two forms of care lay in the combined effect of many factors on dependency level, rather than any simple distinction like 'invasive procedures'. One discussion group urged that each person be individually assessed, and an example was given of a scale marking various factors from 1 to 5 (e.g. can/can't dress/feed self; degree of

mobility; degree of continence/incontinence). If the total score was under, say, fifteen, nursing care was indicated; if above, personal care was most appropriate, (this is like the Norton scale for pressure sore risk assessment, widely used by nurses). A health authority nurse who had used the dependency scale said she had performed an experiment where her assistant visited a home using the scale, she also visited recording her 'gut reaction' for each resident. Not only did the results agree in each case, but also tallied with the matron's own assessment. It was felt that a possible future solution to this problem was that currently being tried in the USA, that is, accreditation of homes on a five star scale. This was not a scale of quality of care or 'hotel' standards, but of dependency level, from intensive nursing care to low level personal care. This may be a way forward, but there are difficulties with using simple behaviour rating scale, and they should be approached with caution.

4. Nursing Care Accountability in Residential Care Homes

Statute requires that nursing care in residential homes should be undertaken by community nurses who, in turn, may delegate tasks to competent staff employed in the home, but only if the community nurse is entirely satisfied that their instructions will be carried out correctly. Where this happens there is some measure of professional accountability through the community nurse and their line manager. In reality much nursing care is given by nurses who are involved in the owning/management of the home or employed within the home. In many cases therefore, community nurses do not enter residential care homes, and lines of professional accountability are absent. There was the additional fear that if no community nursing input was provided in the larger residential homes then this would cloud the picture and support the claim that adequate community resources are available. Registered nurses continuing to practice as such in residential homes are also clearly at risk of professional isolation, unless offered good inservice training at the local school of nursing.

5. Training

The issue of training was not discussed in detail at the conference; a previous conference at the Centre on 1st October, 1986, had been concerned with this issue for the private sector, and will be reported elsewhere. However, participants expressed urgency in establishing a training strategy for the private sector. There was much discussion about joint training between NHS local authority and private sector staff, although this area requires a careful assessment of need for training, including management needs and staff needs. In brief, the conference on **1 October 1986,** summarized management training needs as:

1. Familarisation with, and appreciation of, the legal framework and the dynamics of the rest and nursing home sector.

2. The development of systems and skills in quality assessments and the management of inter-agency relations[13].

The training of care staff should include training in basic caring skills (for rest homes), training to increase staff understanding of diseases and medical conditions of the residents for which they are caring, and, most importantly, training in the development of a philosophy of care which will enhance and improve the quality of life for residents. Overall it was felt that training must take place outside the home and preferably through a registered body, not the proprietor, as a bad proprietor will mean badly trained staff.

There is also the issue of providing joint training courses with inspectors from health and local authorities. Training could encourage the setting up of local consortia for professionals involved in the process of inspection and registration. The aim would be to meet on neutral ground to develop mechanisms for support of individual officers. Bodies such as Council for the Certification of Education and Training in Social Work (CCETSW) would like to see future registration staff have a grounding in social work training, the

RNHA, however, would like all inspecting officers to have a nursing qualification. This clearly leaves much room for further debate and discussion on how a national training body might be run, and what type of qualification would be offered.

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APPENDIX - CONFERENCE PROGRAMME

KFC 87/9

King Edward's Hospital Fund for London

King's Fund Centre

126 Albert Street London NW1 7NF

ISSUES IN NURSING HOMES REGISTRATION

A Forum for Registration Officers and Owners of Private Nursing Homes.

THURSDAY 26th MARCH, 1987

PROGRAMME

Chaired by Professor Malcolm Johnson, Department of Health and Social Welfare, The Open University. Formerly Member of 'Home Life' Working Party which reduced the Code of Practice for Residential Care, 1984.

9.30 am	Registration and Coffee.
10.20 am	Introduction to the King's Fund Centre and the Conference by Helen Smith.
10.25 am	Professor Johnson will describe the aims of the day, and place the conference in context of the current registration system.
	Alison Philips, Registration Officer, Southport and Formby Health Authority. Miss Philips will describe the Registration Pack she has developed for use by owners of Homes. She will also discuss quality of care, including references to innovative practices in Southport such as the Bed Bureau, Matrons' Meeting, Training Sessions, and so on.
11.05 am	George Small, Divisional Inspector, Private and Voluntary Homes, East Sussex Social Services. Mr Small will talk about the practical aspects of dual registration, and comment on the role of Nursing Homes in the future.
11.30 am	Small Group Discussion. Participants will divide into small groups composed of registration officers and owners to discuss and develop the morning's themes.
12.15 pm	Plenary Session with the Panel.
1.00 pm	LUNCH
2.00 pm	Chair to sum up the morning's discussions.

Programme continued

2.15 pm — Dr Patrick Carr, General Secretary of the Registered Nursing Homes Association. Dr Carr will talk about his members' experience of the registration system.

2.45 pm — Mr Christopher Beddoe, Director of the National Confederation of Registered Rest Home Associations. Mr Beddoe will talk about the changing role of Rest Homes since the introduction of Dual Registration.

The discussion will include the positive aspect of the 1984 Act, and the overall benefits of the current working relationships with registration officers. There are, though, difficulties and problems experienced by all parties, and Dr Carr and Mr Beddoe will put forward their suggestions for improvement and development.

3.15 pm — TEA

3.30 pm — Plenary Session with the Panel.

4.30 pm — Chair to sum up the major themes of the conference, and to indicate directions for cooperation and joint working in the future.

4.45 pm — FINISH

PANEL TO INCLUDE:

1 — Mr Christopher Beddoe, Director of the National Confederation of Registered Rest Homes Associations.

2 — Dr Patrick Carr, General Secretary of the Registered Nursing Homes Association.

3 — Miss Alison Philips, Registration Officer, Southport and Formby Health Authority.

4 — Mr George Small, Divisional Inspector, Private and Voluntary Homes, East Sussex Social Services.

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