



Talking Points: Personal Outcomes Approach

Framework of Outcomes Important to People Living in Care Homes

The Talking Points: Personal Outcomes Approach has been developed by the Joint Improvement Team to support a focus on the outcomes important to people using health and social care services in Scotland and their unpaid carers¹. Outcomes in this context are understood both as the goals that service users and carers want to achieve in partnership with services, and as the impact or effect of services on individual lives. The philosophy of this approach is one that emphasises the strengths, capacity and resilience of individuals, builds upon natural support systems and includes consideration of wider community based resources.

At the centre of the Talking Points: Personal Outcomes Approach is a robust evidence base indicating the outcomes important to individuals using services and their carers. Specifically research conducted at the Universities of York and Glasgow has highlighted the outcomes important to people using services and their carers. These outcomes are summarised in two outcomes frameworks one for service users living in the community and one for carers. The framework of outcomes for service users includes three types of outcomes: quality of life, process and change and is presented in Table 1.

Table 1: Outcomes Important to Service Users

Quality of Life	Process	Change
Feeling safe	Listened to	Improved confidence/morale
Having things to do	Having a say	Improved skills
Seeing people	Treated with respect	Improved mobility
Staying as well as you can	Responded to	Reduced symptoms
Living where you want/as you want	Reliability	
Dealing with stigma/discrimination		

^{1 1} Further information about the Talking Points approach including materials and resources to support implementation is available from the Talking Points pages of the Joint Improvement Team website: <http://www.jitScotland.org.uk/action-areas/talking-points-user-and-carer-involvement/>

Between January and May 2011 the Joint Improvement Team with the Social Care and Social Work Improvement Scotland built on this work to develop an additional framework of outcomes important to people living in care homes. This is because the above framework was developed based on fieldwork with people living in the community and has not been systematically reviewed for its applicability with people living in care homes. This development work has been carried out as part of the Scottish Borders Care Home Talking Points Pilot² and has involved three phases of work. These are: a review of the literature; interviews and focus groups with residents, relatives and staff in three care homes and consultation with individuals and organisations with experience of developing an outcomes approach in care home settings.

This work has led to the development of the following framework of outcomes, presented in Table 2.

Table 2: Outcomes Important to People Living in Care Homes

Quality of Life	Process	Change
I feel safe and secure	I am treated as an individual	My skills are improved
I see people	I am valued and respected	My confidence and morale are improved
I have things to do	I am listened to	My mobility is improved
I live in a nice place	I have a say in decisions about my care and support	My health has improved or my symptoms are reduced
I live life as I want and where I want	I am supported to live well and plan for a good end of life	I have settled in to where I am living
I stay as well as I can	My family and friends are involved if I want	
I belong to a community	I can trust staff and rely on them to respond	
	My privacy is respected	

² The pilot was carried out between March 2010 and March 2011 by Gordon Dunbar and Kay Eastwood of the Joint Improvement Team Action Group and Susan Polding-Clyde of Social Care and Social Work Improvement Scotland. For a copy of the report or more information contact Gordon Dunbar (Gordon.dunbar@edinburgh.gov.uk).

Prompts for staff

The following prompts can be used by staff to help them discuss these outcomes with residents (Adapted from the Talking Points Support Pack for Staff, available on the JIT website, link at end of this document).

Quality of life

Supporting people to achieve the outcomes under this heading may require different levels of support at different times. Good support for individuals as they first move into a care home setting is crucial to ensure these outcomes are achieved over time. Engagement of staff in the care home, the person themselves, other health and social care professionals, family, friends and the broader community may be necessary to support the individual to achieve these outcomes.

I feel safe and secure: The person feels safe and secure in the care home and in their community. The person is as far as possible physically safe from harm, including risk of falling. The person also feels emotionally safe and can rely on care home staff and others to support them when they feel less safe. Relationships with other people who live in the care home may have an impact on experiences of safety. Where significant concerns about risk arise consideration should be given to a risk assessment being undertaken.

I see people: The person feels that they have enough contact with significant other people and that they have opportunities for social participation, if they choose to (to avoid isolation). This can include family, friends, other residents and staff. Individuals have some choice over who they spend their time with in communal areas of the care home.

I have things to do: The person has opportunities to undertake activities which interest them, both in the care home and outside the home (if they wish). This can include hobbies, voluntary work and education opportunities, where that is possible.

I live life as I want and where I want: The person is able to plan and have control over their daily life, such as what they wear, when and what they eat and how they spend their time. The person has ability to reach key decisions about their life and future recognising the limitations of living in a group environment/ setting

I stay as well as I can be: The person feels that they are as physically and mentally as well as they can be, given any illness or condition they have. This includes being supported to stay clean and comfortable, having access to appropriate and nutritious food and drink and support with and treatment when the person becomes ill, and the management of any long term conditions, including managing medication.

I have a nice place to live: The person feels that they live in a pleasant and homely environment. This includes the space inside the home, any outside space and the environment in which the home is situated.

I belong to a community: The person is able to participate in the community of their choice. This may be the community within the home or a community that they previously associated with before coming into the care home, e.g. local church group. The person is able to participate in community life regardless of illness and disability.

Process

Outcomes under these headings are the impacts of the way care and support is provided and the ways in which staff engage with people. This includes care and support provided in the home and by other health and social care professionals.

I am treated as an individual: The person feels that they are recognised as an individual in their own right, with individual needs, aspirations and preferences. Their experiences and achievements are recognised and respected.

I am valued and treated with respect: The person feels that they are valued as someone who has something to contribute and are respected and treated with warmth and consideration.

I have a say in decisions about my care and support: The person's views are taken into consideration in deciding on the support they receive and how the routines in the home impact on their life. This includes the use of sensory and communication aids as appropriate. The person is supported in anticipatory care planning ('thinking ahead'), to ensure their preferences are known.

I am supported to live well and plan for a good end of life: The person has the opportunity to plan for the end of their life, including where they would like to die and the arrangements for after they have died. This process may be facilitated by the use of a specialist care pathway.

I am listened to: The person feels that their views about their own situation are listened to by staff and their communication is supported. This includes the use of sensory or communication aids as appropriate.

My family and friends are involved if I want: The person feels they are able to involve their family and friends in their life, including making decisions about and providing care and support. There is recognition of the importance of the continued relationships and the role of family and / or friends as the person moves into the care home

My privacy is respected: The person is able to be alone when they choose and to receive care and support and pursue interests and relationships in private.

I can trust staff and rely on them to respond: The person feels that they can rely on staff to do what they say they will and to ensure that care and support that they need is in place. The person feels that services respond to their changing needs and that they can rely on services to respond if particular difficulties arise.

Change

Change outcomes result from tackling barriers to achieving quality of life and from managing risks. For some people it may be possible to identify a point at which the change has been achieved or partly achieved, and the focus moves to maintaining quality of life.

My skills are improved: Relevant where staff are supporting the person to regain skills and capacities

My confidence / morale is improved: The person is working towards dealing positively with changed life and health circumstances, and/or personal and societal attitudes towards ageing, ill health, long term conditions, disability and dying. This outcome may be particularly important when the individual first moves to a care home and at the end of life.

My mobility is improved: The person is working towards improved ability to get around within the home and/or outside (includes equipment, adaptations, therapy, transport)

My health has improved or my symptoms are reduced: Experiencing fewer symptoms, feeling less depressed or anxious, improved sleep and improved relationships. Symptoms continue to be managed to enable the person to approach the end of life in comfort and to have a good death. Where the person has dementia, they are supported to manage the impact of the cognitive impairment on their health and wellbeing.

I have settled in to where I am living: The person is working to establish their life in the care home and to adjust to the changes associated with a move to a care home. This may include taking time to come to terms with feelings of grief or loss associated with leaving a previous home.

July 2011

Ailsa Cook, Gordon Dunbar, Kay Eastwood, JIT Action Group and Susan Polding-Clyde, Social Care and Social Work Improvement Scotland

With thanks to the residents and staff from the three care homes who participated in this work and to colleagues from Scottish Borders Council, Talking Points Learning and Action Group and Thistle Foundation for their invaluable comments.

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