

Taking the community into the home

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Abstract

The changing demographics of the population are such that there is an increasing need for care for frail older people with both physical and mental health problems. At the same time, the increased migration of workers and their families means that care provision now has to embrace a range of cultures. The present paper explores how the concept of cultural safety has importance for those planning and providing care for older adults. The recognition that removing individuals with mental health problems from their own environment causes increased disorientation and confusion has led to some organisations trying to maintain the community aspects of life when independent living is no longer possible. The present paper focuses on two such organisations in the Netherlands, demonstrating how they have changed their practice to improve and enhance the quality of life of their clientele through 'taking the community into the home'. Whilst sharing the same goals and aspirations, each organisation, serves a different population, and therefore, has developed a unique approach.

Keywords: care of the elderly, cultural safety, innovations in care

Introduction

The problem of the provision of services to meet the health and social care needs of older adults from diverse and differing communities is frequently cited in the media. However, whilst such publicity helps to raise the profile of this group, few solutions are offered. Indeed, across Europe as a whole, the ageing population is placing increasing strain on both the established healthcare service and on families. Until the late twentieth century, the outlook was bleak for those whose families could no longer cope with the behaviour and living patterns of their relative, or for those individuals without support. Transferred into a specialised unit, they lost many of their own cultural patterns of living, a situation that contributed to their sense of loss and distress.

However, in recent years, there has been a major societal change intended to recognise and endorse 'fragmentation and plurality' (Dyck & Kearns 1995, p. 137). In healthcare terms, this has led to a change in perspective. In direct contrast to the orthodox medical

model, there has been a recognition of the need to acknowledge difference, and to recognise cultural patterns and practice in care through the development of culturally sensitive and culturally competent care (Klem *et al.* 2001), and now culturally safe care (Ramsden 2000, Dyck & Kearns 1995). This last concept is of particular importance for vulnerable groups such as older adults, and in the field of mental health, since its concern with the power bases in healthcare interactions (Ramsden 2000) enables potentially disenfranchised individuals to be, at the least, cared for within understood and/or familiar settings. Where possible, these people can be increasingly involved in their own care planning and in decisions involving their own future. For this to be possible, healthcare professionals have to be conversant with the history and contemporary circumstances of those for whom they provide care. In this context, care planning places an increased focus on the minutiae of daily life, using these as a means to construct reality for the individual. Thus, cultural safety goes further than acknowledging that health outcomes are influenced by factors such as race, gender, culture

and socio-economic status. It aims to bring together the previously ignored, or little valued, issues around the social relations of place, knowledge and identity, and the medical model of care previously advocated. Two major advantages of this approach are that it prevents the 'whiting out' of difference (Jackson 1993), and terms such as race and culture cannot be used to hide, or ignore, institutionalised and individual racism within healthcare provision (Ahmad 1993, Spence 2001).

Although most healthcare professionals would now accept this approach as appropriate, finding examples of cultural safety in practice is not easy. However, in the Netherlands, two different but good examples of how the principles of cultural safety are being used to facilitate high-quality equitable care can be found in Hogewey in Weesp and De Schildershoek in Den Haag. These two organisations serve different populations and use their own distinct approaches, but share a philosophy that puts the client first. Both prefer to use the term 'client' rather than 'resident' or 'patient' because of the connotations attached to these terms. Both have demonstrated a saving in the cost of care provision since adopting the approaches outlined below.

Care for older adults in the Netherlands

Before describing two organisations, it is necessary, to provide an explanation of how care for older adults is provided within the Netherlands. As with the rest of Europe, the demography of the Netherlands is changing. An increasing percentage of older adults is aged over 75 years, which means that, even with overall improved health, there is more demand for extended care. At present, it is estimated that there are over 2 million people of pensionable age. By 2020, this number will have increased to almost 3 million, and by 2030, it will be around 4 million. The consequence for the economy is an ever-increasing healthcare cost, which raises the question of who should pay the price. In the Netherlands, there is no single national health service. Instead, there is a complex set of insurance-funded private and public healthcare organisations. Each organisation focuses on the group it is contracted to serve, and there has been no overall or unifying approach. Although it is predicted that the percentage of the total population needing care will not change (VWS 2003), in real terms, home care and nursing homes will ultimately have to cater for more people who are likely to have increasingly complex needs, with considerable numbers needing both physical and psychiatric care (Schrijvers 2001). At present, in an effort to resolve the problems, major changes in the planning and implementation of services are in progress (Etty 2000). In the long term, the situation may improve, but

at present, as with the UK, there is a shortage of care provision, and a waiting list for nursing and residential homes.

There is also tension between the increased need for care, and a financial climate that has, in real terms, a reduced budget and an emphasis on cost-effective accounting (Kemenade 1997). In addition, there are concerns about care standards, in part because older adults are increasingly well informed and are also forming alliances to further their shared interests (Bosselaar *et al.* 2002, De Vries *et al.* 2002, Snijder 2003). At the same time, the policy of the Dutch government is to promote change to ensure that the autonomy and the self-determination of the client group are seen as paramount, together with respect for the individual, and that support enables the individuals to maintain control over their own lives for as long as possible (Vliegenthart 2002). Dutch health policy emphasises the importance of the clients' wants and needs in the development of care packages. Specific legislation has established residents' advice centres and research has revealed different levels of satisfaction with the care provided (Snijder 2003).

Theoretically, much of the care of older adults has been established using a holistic approach, but in spite of mission statements and impressive aims, sometimes short-term goals are altered by practical considerations, aims are not always achieved and little change actually takes place. However, the two examples presented here have both managed to successfully implement a vision of culturally safe care.

Hogewey: living as usual

Hogewey, in Weesp near Amsterdam, caters for those with dementia who can no longer continue to function in their own home. The staff describe those in their care as 'living with a restriction but also with an added value' (Hogewey 1995). There are places for 167 people who are referred from across the Netherlands, and not surprisingly, there is a waiting list. Despite this, Hogewey has an excellent track record of quickly admitting those in urgent need. Staff have pioneered and established an approach that enables clients to continue to live in the manner to which they were accustomed prior to the onset of dementia. The staff argue that moving people with dementia into residential care is unsettling and can cause further deterioration in their ability to cope. To minimize this disturbance, they have developed 'homes within homes' using 15 'lifestyle groups' based on seven different lifestyles. These groups have evolved following detailed study of the cultural patterns and practices which exist across the Netherlands. Staff recognise that, even where individuals come

from the same region or town, their social circumstances will have led to the formation of distinct and different patterns of living. The seven lifestyles are: *Gooise* or aristocracy, a term originating in a very wealthy area of the Netherlands; *Culturele*, a term that has no literal translation, but refers to a lifestyle based around the arts, classical music, history and other cultural events; *Amsterdamse*, based on the type of life lived in the crowded urban areas such as Amsterdam; *Indische*, referring to people from Indonesia, a former colony from which many people immigrated to the Netherlands; *Christelijke*, referring to those who have always followed strict Christian religious observance; *Ambachtelijke*, meaning those used to a particular type of working class lifestyle; and *Huiselijke*, meaning those whose main focus was homemaking, working as housekeepers or what was regarded in the past as being in domestic service. Each group has its own pattern of daily life and activities which reflect what, for them, are the ordinary, everyday lives which individuals would have lived when in the community. Hence, visitors find themselves transported from a setting that could be found in any large, urban conurbation (*Amsterdamse*) to one reminiscent of high society (*Gooise*) and then onwards to what appears to be another culture altogether (*Indische*).

Each individual is separately assessed and then placed within the lifestyle group that matches as nearly as possible their pre-admission life. Emphasis is placed on establishing the type of work they did, their religious beliefs, their social class, their cultural patterns and practices, their hobbies and interests, and on finding ways to facilitate activities which help to keep them anchored in reality (Raad voor de Volksgezondheid en Zorg 2000).

Looking around Hogewey, the immense achievement of the lifestyle groups is immediately apparent. There are busy groups in progress and even those with severe difficulties are involved in the life of the group as a whole. Examples include the following: For those from the *Gooise* who are used to a formal and ordered lifestyle, formality is maintained, even to the decoration of the living rooms with lace tablecloths and the availability of sherry before meals. In contrast, in the *Amsterdamse* groups, a much more informal style exists, reflecting the patterns of living and social interaction which occur amongst those living within densely populated cities such as Amsterdam. Yet another contrast is present in the *Indische* group, where the decoration, activities and food all reflect the lifestyle that those living in or originating from Indonesia would have experienced.

In the *Huiselijke* group, the majority of clients are women who have always seen themselves as homemakers, and who may feel lost, bereft and without

purpose if they no longer have a home to run. Although no longer able to live alone, they are encouraged, under supervision, to continue their familiar routines for the benefit of the group as a whole. They may well participate in meal preparation, general housework, and where appropriate, the laundry. There is no longer a central laundry; each group is responsible for all normal household tasks. To facilitate this, there is a portable kitchen, consisting of additional cooking facilities that can be plugged in, that can be brought in to supplement the existing kitchen arrangements. This focus on normal living runs counter to many homes where, once admitted, the individual plays no further role in running what is, after all, their own home. Life at Hogewey encourages a return to and the maintenance of purposeful activity. The effects were evident in the confidence with which the activities were carried out and the general atmosphere of contentment. No individuals are required to participate in activities, but most choose to do so. They find security, and in many instances, show decreased signs of distress and confusion as they are gently encouraged to carry out known and familiar actions. Inevitably, this has meant staff accepting that their role has expanded too, and incorporates running a household with additional responsibilities rather than running a ward.

Each group of clients has its own living space, called a 'house', and as with the clients' own homes, each front door has a bell. Staff and visitors alike use these bells and request permission to enter, rather than entering as a right. Within the group, clients are encouraged to continue normal daily activities, and therefore, each household has a budget within which they have to manage. There is also a small supermarket that can be used to buy food, medical and care supplies. Food can either be cooked within the household or Hogewey's restaurant will provide take-away food. For those who prefer to eat out, meals can be eaten in the restaurant of the main building. Perhaps one of the biggest changes in financial management is that, if a home manages to stay under budget, the remaining funds can be used to buy additional comforts, items which will either improve quality of life or make life easier; for example, a new coffee percolator.

Small alcoves are situated around the main building, all reproducing familiar scenes, such as woodlands and the seaside. These provide both visual and auditory stimulation. It is accepted that clients may wish to sit there alone, and if so, their privacy is respected. There is also a bar/café where residents and their families can sit and relax, much as they would have done in a café or bar in the past. The décor of this is such that it is difficult to believe that it is inside the organization, particularly since it is staffed and run as a separate entity. In addition

to a range of activities within each group, there are central activities, such as concerts, where residents and their families can enjoy an afternoon or evening out together. Indeed, family and friends are encouraged to visit as much as they wish, and are seen as a vital link with the client's past and present life. Individuals can and are encouraged to attend these activities, but because of the way in which they live, these activities are viewed as separate from daily living. Thus, for example, concerts become evenings or afternoons out, much as they are for those living in the wider community.

On a more practical level, there is a hairdressing salon for the women, while men can attend a barber's. The emphasis is on 'going to', not being brought to or visited in the home. If clients are unwell, there is a general practice surgery available and home visits are only for those unable to go under their own volition. Finally, and in a major change to most organisations, those admitted who have pets are not forced to part from them. Instead, they can bring them with them, and they become part of the household they join.

The appearance of 'normal' life is facilitated by the staff, who do not wear uniform, and who display a positive commitment to their work and to maintaining normal life for their clients. Staff satisfaction is reported to be much higher since the current approach started, and the turnover of staff has considerably decreased. The local community also plays a key role in enabling Hogewey to function in this manner by participating in activities, and even being able to order food from the restaurant.

Perhaps not surprisingly, Hogewey has won both national and international prizes for this work, and the staff are justly proud of the change from traditional care to an approach that not only recognises individuality, but values it and positions it within a cultural context supporting the traditional patterns and practices of life. Although Hogewey has residents from across the Netherlands and clients from minority ethnic communities as well, on the whole it is the diversity of the Dutch lifestyles that is addressed here. Careful assessment is used to enable clients from minority ethnic communities to fit into one or other of the lifestyle groups, with life within that group adapting accordingly.

De Schildershoek: coping with ethnic diversity

The second example has taken a very different approach to that of Hogewey by responding directly to an increasingly diverse population. By the year 2000, there were 1.4 million people from minority ethnic communities resident in the Netherlands, and it is estimated that this number will have risen to 2 million by 2010, of whom an estimated 190 700 will be over 55 years, with nearly 19 000 over 75 years (De Veer 2003). Although

there are plans for future care, there is a serious lack of appropriate care facilities available today, which means that much of the care burden falls on the families (Schrijvers 2001).

In response to this problem, De Schildershoek, a nursing home based within de Schilderswijk, a very deprived, multiethnic community in The Hague, has developed care packages specifically designed to enable those in need of care to retain their cultural patterns and practices whilst living within a safe environment. The home has 180 beds, 60 for those with physical illness and 120 for those who have mental health problems such as dementia, and 15 day-care places.

The home has clients from a wide range of groups. In the past, Hindu people formed the largest group in the locality, and whilst members shared some beliefs and practices, they did not all originate from the same area, a factor that meant care plans could be fairly diverse. Nowadays, there is no single minority ethnic group in the locality and the home receives clients from almost every community present in the Netherlands. The multiethnic nature of the clientele is one that the staff of De Schildershoek has positively embraced. The entrance to the home reflects its multicultural nature. There is a large display of artefacts from the communities served, with paintings and murals adding to the sense of shared and different cultural patterns and practices. Communal areas have been designed to reflect community life, and to provide areas where individuals and small groups can have privacy. Families are encouraged to play a role in their relatives' care, and the communal areas provide appropriate places for them to meet and sit.

Each individual is seen and assessed not just as someone needing care, but also in the light of their cultural patterns and practices. Considerable time is spent with clients and their families exploring how each individual lived, their social history, their hobbies and interests, as well as their care needs. With this approach, care packages can mimic as closely as possible the individual's life in the community. The policy is 'to listen, listen and then listen again' to make sure that both sides are clear regarding the needs of the individual and that subtle nuances have been understood. Linked to this is a strong emphasis on respect for the individual, of 'respect, respect and respect'. Every effort is made not only to establish appropriate care, but also to ensure that key issues such as food are appropriately prepared and presented. With so many different needs, De Schildershoek has recognised the importance of demonstrating to individuals and families that no taboos are crossed, and thus, there is open access to all areas. For example, families are welcome to check the way staff have divided the kitchens and the way in which individual meals are prepared.

A major problem for staff is that those with dementia often lose their second language, in this case Dutch, and communications become increasingly difficult (Asperen 2003). To overcome this, De Schildershoek has, where possible, actively recruited staff from the minority ethnic communities served, and thus, individuals can be cared for using their first language. Where this is not possible, De Schildershoek has an extensive range of translated materials, including Chinese and Mandarin, which staff can use to facilitate understanding. As at Hogewey, De Schildershoek has developed a programme of activities which the community can participate in. These include concerts or recitals of different types of music, and whole evenings devoted to exploring the lifestyles of the different communities.

The interactions between staff and clients, clients and clients, and clients and families reflect a relaxed and caring atmosphere. Families and friends are much in evidence and interact with other clients as well as the person they have come to visit. There is no evidence of the traditional images of the care of elderly people. Staff believe that their approach, which maintains much of the familiarity of the clients past life, helps to anchor clients in reality, enabling them to contribute positively to their families and to the lives of other residents. Such contributions and the success of De Schildershoek overall is the result of the development of clear policies and continuing efforts to reconcile different ways of life. As the manager pointed out, belonging to one minority ethnic community does not guarantee acceptance of all others, and when De Schildershoek first developed the approach outlined here, staff found racism not only between clients, but also towards and sometimes unconsciously from staff (Spence 2001). De Schildershoek does not tolerate racism in any form, and spends time ensuring that both staff and clients learn about each other, believing that with understanding comes acceptance and respect for the individual (Asperen 2003).

Conclusion

Both examples given can be seen as pioneering attempts to merge care provision into the community, thus taking the community into the home. Both Hogewey and De Schildershoek firmly reject the term 'patients' in favour of 'clients', seeing this term as more appropriate with less of a power bias to the organisation (Heymann 1995, Fraher & Limpinnian 1999). Both organisations are catering for very different communities, and hence, have evolved patterns and practices which share similar core beliefs and mission statements. Each has moved from a traditional approach to one that values the individual (Dyck & Kearns 1995, Bosselaar *et al.* 2002). Each has recognised and implemented an approach that

minimises the changes and accompanying disorientation for a group who cannot speak or argue on their own behalf (Fraher & Limpinnian 1999, Bosselaar *et al.* 2002). Both have taken situations which are usually regarded as constraints and turned them into strengths. One has addressed the issue of diversity among elderly people through lifestyle groups, the other through building upon the uniqueness of the individual. Together, the two illustrate that there is no one way to provide culturally safe care. It has to be based on detailed assessment of need (Visser & De Jong 1999). If not applied with vision and forethought, either approach could be used to reinforce traditional institutionalised care. In Hogewey, the concept, if carelessly applied, would lead to stereotyping patients, and in De Schildershoek, they would be lost in the diversity. It is a tribute to the strength of commitment shown by both groups of staff that this has not occurred.

The importance of maintaining normal life (Visser & De Jong 1999, Bosselaar *et al.* 2002) clearly shows positive benefits, and staff in each organisation could give examples of how their approach had enabled clients to gain confidence and interact more fully with their families and carers. Importantly, for continuity of care, both groups of staff reported increased job satisfaction, and hence, less turnover, thus further increasing the sense of security and normality for the clients.

Both organisations are based in established buildings, not new or purpose-built homes, and each has shown considerable imagination in the ways in which they have removed traces of traditional nursing homes. Perhaps one of the most impressive parts of the changes is that neither home received additional funds to facilitate the change. Instead, each has acted within established budgets, giving the term 'creative accounting' a new meaning (Jenkinson 1997), and each has made financial savings which have been reinvested in care provision. This may be in part because, as one manager pointed out, the traditional attitude of ordering in bulk can lead to waste. Now staff are directly accountable for what is used, and orders reflect what is actually needed rather than 'what we've always had'. Both organisations are hoping to be able to make further improvements and, ultimately, provide all clients with individual rooms, instead of the small two- or four-bedded rooms which they have at present. Whilst these have been personalised as much as possible, staff in both homes want more for their clients, and continually strive to make improvements, moving ever close to their ideal of culturally safe care.

The approaches used in Hogewey and De Schildershoek, although dissimilar in practice, demonstrate how the differences between individuals can provide a strength and an added benefit that improves and

extends the experience of all (Dyck & Kearns 1995), including the staff, who have been able to develop programmes which offer holistic and culturally safe care (Ramsden 2000). For relatives seeking to find a safe haven for loved ones whom they can no longer support alone, these homes provide a unique set of memories. Not only providing high-quality care, but the opportunity to see and remember a parent, relative or friend at their best, physically and emotionally supported, surrounded by their peers, and participating, albeit in some instances to a limited degree, in life-enhancing activities. In short, they offer what all of us would want and many despair of finding for our own families.

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