

related activities and projects.

Megan Hunt, a healthcare assistant, social carer and PDU co-ordinator, said: "By taking an inclusive approach with relatives, we have encouraged them to think of where their loved one is living as their second home too. We are taking the opportunity to bring everyone together as a community, ensuring everyone's opinions are valued. It has been an ideal way to rejuvenate our way of working and modernise our care services."

Nicki Ayres, whose grandmother has been a resident at The Aldbury since May 2010, was invited to become involved in the PDU process at an early stage. She gave a talk at Bournemouth University to Colten Care staff about dementia care from a relative's perspective. Mrs Ayres said: "The inception of the PDU has really focused the staff's minds on what they do with residents and has led to a greater depth of understanding and compassion. The PDU has also made life at the home less rigid and more fluid, meaning residents get more from each day. I believe the PDU has made a vast difference to the lives of all involved."

Another relative, Joan Harrison, said: "When the PDU project was explained to me along with its benefits and how it was being applied I could see significant and beneficial changes in the home. There seems to be so much more activity and interaction for the residents as well as creative and innovative work being put into the home. I find the changes to be beneficial and wonderful."

Colten Care are pleased to announce now that, following a successful inspection in March 2012, the homes have been accredited for the normal PDU period of three years. Every year they will submit a report describing progress to date and further development plans.

■ Karen Fuggle is Head of Learning & Development and June Gallagher is Operations Manager at Colten Care.

TALKING POINT

Dementia doesn't cause 'sundowning' – we do

I recently had the pleasure of visiting with a woman at our care home who experiences frequent distress in the late afternoon. I was immediately struck by the connection of her anxiety and desire to leave with a lot of change-of-shift activity. This leads me to suggest a larger discussion about the whole concept of what we call 'sundowning'.

There has been much discussion and debate about the late-day distress that many have termed the 'sundown syndrome'. The prevailing medical view is that it is a consequence of brain changes associated with dementia. Many also feel that environmental cues can exacerbate the condition. I am going to suggest that perhaps this view "puts the cart before the horse".

More and more, I have come to see the sundown syndrome as a classic example of what Dr Tom Kitwood called 'positioning', meaning that we blame the distress on the disease, rather than looking for other factors. Consider this scenario:

Whenever I teach a three-day Eden Alternative course, I can guarantee that around 2-3pm, some of the people in the class will get up, walk around a bit or stand in the back for a while. They are usually nurses and personal care aides. Are they 'sundowning'? Agitated? Of course not. Most day shift nurses and aides work from 6 or 7am till 2:30 or 3:30, and they are on their feet most of the day. But I take them away to this course and shift their workday to an 8-5 schedule and make them sit most of the day. I force people into a rhythm that is different from their usual pattern, and by mid-afternoon, their bodies start to rebel.

I suppose I could shift the class to 6am-3pm and create more opportunities for walking around, but instead I schedule it around my own work needs and I usually get so caught up in the process that I don't think to get people moving around more. Does any of this sound familiar? Welcome to long-term care.

I am going to suggest an alternate idea. Dementia does not cause 'sundowning' – we do. Dementia simply 'fans the flames' by making people (1) more sensitive to their environment, (2) more easily fatigued, and (3) less able to cope with having their biorhythms shifted into artificial schedules that better suit our care home operations.

This is a small distinction, but a very important one. Here's why: We cannot cure dementia, but we can cure almost all cases of 'sundowning' without medication, by shifting operational patterns and staff behaviour.

Still not convinced? Ann Wyatt of the New York City Alzheimer's Association has written in their recent newsletter of how Beatitudes, a care home in Phoenix, Arizona shifted operations and staff behaviour, with overwhelmingly positive results.

The home had already begun to implement a philosophy where achieving comfort was the overall staff goal. As Ann Wyatt explains, "This comfort philosophy was not about an end-of-life focus, but rather about meeting the needs of people with dementia the way they would do for themselves if they were able." This was a big change as it meant stepping away from established schedules and routines, to embrace the routine of the individual with dementia. The team observed everyone on the unit between the hours of 2.30pm and 9pm. They saw that many residents looked tired or frazzled, and wondered if they would be more comfortable if they were to lie down and rest. These rest periods were not necessarily convenient for staff, and some found it challenging at first, but the team decided that whenever someone looked tired, no matter when it occurred, even during mealtime or an activity, they would assist the person to rest in a comfortable chair, on their bed, or in bed if preferred. This was very successful. As residents started to sleep when they were tired and wake when rested, they were happier and needed less psychotropic medication.

Staff then went on to address the noisy and chaotic atmosphere on the unit, especially just before the evening shift change. As Ann Wyatt comments, "It can be easy to forget that being confused and unable to make sense out of the environment can be extremely tiring for the person with Alzheimer's, and over-stimulation makes this worse." Staff were amazed that making comfort the goal of everything had such a positive impact on the residents and on themselves. With a quieter environment and the 'rest as needed' policy, the home has been virtually 'sundown-free' for 14 years and has eliminated almost all of its psychotropic medication as well.

I would encourage you to share this information with your teams and begin to look at how we might be able to create a more natural experience that honours the individual rhythms of our elders. This is powerful stuff, and a great example of how culture change improves not only quality of life, but clinical care as well.

■ Dr G Allen Power is Eden Mentor at St John's Home in Rochester, New York, Clinical Associate Professor of Medicine at the University of Rochester and author of *Dementia beyond Drugs: Changing the Culture of Care*. He will be a keynote speaker at this year's UK Dementia Congress (see p4).

Dr Power's blog is at: <http://allenpower.wordpress.com/>

Free Comfort Care guide at: <http://www.alz.org.illinois>

New York City Alzheimer's Association newsletter at: http://www.alz.org/nyc/in_my_community_22103.asp



by Dr G Allen Power

Feelings matter most – DVD series

The first four DVDs in a planned series of eight are now available from Dementia Care Matters. The first, *Feelings in dementia care matter*, is a learning tool and introduction; the second, *Experiencing the truth in dementia care*, demonstrates the power of regular observation, sitting in a care home lounge for example, to see, hear and feel people's lived experience; in the third, TV presenter and author John Suchet interviews Dementia Care Matters' chief executive and founder David Sheard; the fourth focuses on leadership: *Leading with heart in dementia care*.

More information at www.dementiacarematters.com or tel 01273 242335