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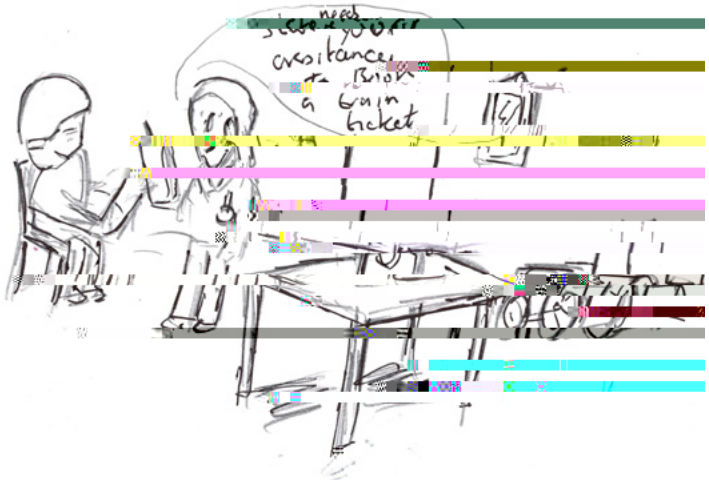
As a care home with nursing, we support people who require nursing care. We refer to our residents as ‘family members’. The majority of our family members are over 65 years old.



However, we also support younger physically disabled persons from the age of 45 years.

We can meet a broad range of care needs such as:

- general nursing care of older people
- those with physical disability
- those with mental illness/learning dif□culties
- those in need of rehabilitative care
- those living with a dementia
- those requiring end of life care.

Staff at Wren Hall strive to deliver person-centred relationships focused care. This means we deliver individualised, personalised care to each person recognising the people, pets, activities, and objects that add meaning to their life and being. Our approach involves:

- recognising, supporting and celebrating each person
- the creation of a homely place to live, work and visit
- the provision of specialised care and support
- promotion of wellbeing
- supporting life skills and individuality
- enabling freedom though choice
- providing a meaningful environment where someone can live and not just exist
- involvement of a family, friends, partners, pets, hobbies and belonv1cp mthovv

In addition to residential services, Wren Hall offers day care. This service supports individuals to remain living as independently as possible at home and offers socialisation, meaningful engagement and occupation outside of the home setting.

Wren Hall embraces relationship-centred care with the aim of building stronger relationships. This takes person-centred care one step further with the recognition that to enable family members to be happy and ful□lled, we must understand their past and present relationships with others. This re□ects the importance of interactions among people and recognises that these provide the foundation of any therapeutic care activity. We embrace a three-dimensional approach between our family members, their family and friends and our staff team. Throughout our support and care delivery of an individual we recognise the relationships which are of importance to the person. These relationships may be with people but may also be with pets, nature, sports, religion etc. These are the things that give meaning to a person's life. This approach informs the delivery of personal care. It means that we are committed to joint decision making and shared care planning with the family member and their relatives.

Tailoring communication approaches to the individual with dementia is crucial to relationship-based care. The student nurse is likely to develop their understanding of such approaches as:

- “Dementia Capable” care, a form of positive behaviour support, that offers guidance on the most effective ways of responding to individuals when they are anxious, agitated, experiencing a distress reaction, and also in tension reduction.
- Total communication approaches which use all means, methods and opportunities to support individualised communication.
- Life history work.
- Making use of the “Therapeutic Lie” which involves entering the reality of the person in order to support them without creating agitation e.g. not challenging if a family member is focussed on the need to go and collect their child from school, going along with this until it is possible to distract them onto other things.

Most family members lack the mental capacity to make many decisions because of their dementia. As a result, most need a deprivation of liberty safeguard in place to ensure the individual is legally residing at Wren Hall. The student nurse will observe mental capacity assessments being conducted by best interest assessors, mental capacity assessors and you will witness the involvement of paid representatives. You will gain knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards. You will gain insight as to when and how to make safeguarding referrals.

rehabilitation	application of infection prevention and control, practices and environment	risk assessments (environmental, moving and handling, medication)	venepuncture
catheterisation	vaccination and immunisation	tracheostomy care	percutaneous gastrostomy tube care
undertaking and recording of clinical observations	use of SBAR or News2 to monitor and relay clinical information	continuous clinical and risk assessments for each clinical domain	managing deterioration
dietician nursing	healthy diet programme	Promotion of health awareness	medical health reviews
knock on effects of poor discharge	understanding frailty	understanding falls risk intensive support interaction	effective discharge planning from hospital/ sharing information – MDT include home care agencies to reduce re admissions
introduction to concept of telecare	Ongoing monitoring – e.g. must/waterlow/weight loss	GP oversight	monitoring of various conditions i.e. diabetes management.

- gain an understanding of “relationship-based” care and, in particular, the importance of this in identifying and supporting the needs of those people living with dementia
- build experience of engaging and supporting a person with dementia or other long term health condition in their daily living
- get involved with development and implementation of health and care plans including the undertaking of health checks
- participate in collaborative working with MDT professionals
- develop understanding of the social policy and regulatory frameworks in which social care is provided, and the implications for the nursing role.

The student nurse will build their understanding of the policy framework in which social care operates and the role of the nurse within this. They will find out about the reality of working at the interface between health and social care services.

They will develop their confidence as a professional leader and understand their responsibilities for modelling excellent practice to others in the care team.

They should experience clinical supervision and develop their reflective practice.

Staff members likely to be working alongside the student nurse include:

1. The managing director (a registered nurse) has overall responsibility for the running of the nursing home and as such has control of formulating company policy, financial planning, business strategy, family member care, staffing matters and control of drugs. She is supported by a team of other colleagues with responsibilities for staff recruitment, training and quality, health and safety.
2. The clinical and care team which comprises:
   - a team of 10 registered nurses
   - an assistant practitioner who supports the registered nurses and leads the care team
   - nursing associates who supplement the nursing team acting as a bridge between the care assistants and the registered nurses thus supporting the health and wellbeing of “family members”
   - care coordinators who lead the teams of care assistants in providing person-centred relationship focused care
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2.

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[illegible] (PBS)

PBS is a distinct role of the senior leadership team. This involves working alongside the care team to aid identification of triggers that lead to distressed reactions. Positive behaviour support coaches support meaningful activities and reduce behavioural incidents and by doing so increase a person's wellbeing whilst also reducing the experience of ill being.

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Occupational therapists visit our family members to offer advice and support regarding meaningful activities, most suitable equipment e.g. specialist seating etc. The occupational therapists are usually part of the Dementia Outreach Team which offers supports to individuals living with a dementia who are experiencing behavioural issues.

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Medical practitioners will visit to see a specific family member as necessary. The Primary Care Network (PCN) is moving to a 'one care home one practice' approach based on research evidence which suggests this approach offers optimised care. You will see GPs visiting, examining family members and collaborating with our nursing team. You will also see how our nursing team interfaces daily with the GP practice.

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Many of our family members experience swallowing difficulties and this can result in them aspirating and developing chest infections. SALT assess our family members eating and drinking and recommend the most appropriate fluid and diet consistency using International Dysphagia Diet Standardisation Initiative (IDDSI). You will be able to see our catering team provide textured modified food and fortified drinks for our family members.

Family members are referred to NHS Dieticians by their GPs if we have concerns regarding weight loss or weight gain. The

This setting can offer the opportunity to experience activity that links to the following NMC pro□ciencies, click on the pro□ciency to be taken to the full criteria: