Current practice of Namaste Care for people living with Dementia in the UK

Background

Care homes can struggle to meet the needs of their most dependent residents. Untreated or undertreated pain is commonplace (Corbett et al., 2012) leading to distress, disturbed behaviour, depression, decreased functioning and increased dependency (Care Quality Commission (CQC), 2015). In particular, people with advanced dementia often become isolated, which compounds negative health outcomes. Care staff frequently struggle finding appropriate interventions to engage people at these later stages.

Namaste Care is a multi-component approach that aims to enhance quality of life of those with advanced dementia through a combination of physical, sensory and emotional interventions. "Namaste" is a Hindu greeting meaning 'to honour the spirit within'. The approach was developed by US practitioner Joyce Simard who recommends integrating Namaste Care into a daily regimen with sessions delivered twice a day, morning and afternoon, by care workers who are allocated the role of Namaste Care practitioners (Simard, 2013). A manual and toolkit have been developed to support Namaste Care practitioners, and training workshops have been delivered in the UK since 2012, (Stacpoole et al., 2014). The manual recommends that Namaste Care sessions take place in a specially prepared room or area with low lighting, soft music and comfortable seating. Each resident is warmly welcomed. Residents are assessed for pain and offered frequent hydration and preferred foods during the session, to meet need but also stimulate senses. Tactile interventions and 'loving touch' form an integral part of the approach and may include hand massage, foot spa and hair brushing. Music, singing, dolls, pets and nature are utilised within the sessions according to individual preference and need.

A research evidence base regarding Namaste Care is beginning to emerge. A US study across six centres with 86 people with advanced dementia, found that 5-hour daily Namaste practice, resulted in a significant decrease in withdrawal and agitation, a reduction in delirium indicators and anxiolytic medication (Simard and Volicer, 2010). A UK action-research study in five nursing homes showed

significantly reduced behavioural symptoms and occupational disruptiveness in four of the participating homes (Thompsell et al., 2014; Stacpoole et al., 2014). A further UK 9-month pre-post study in three care homes described reduction in challenging behaviour and depression for ten out of 14 participants (Soliman and Hirst, 2015). Namaste Care implementation has also been associated with a significant reduction in anti-psychotics and hypnotics for nine residents of a Scottish nursing home, alongside a reduction in sleep disturbance and positive family appraisal (Fullarton and Volicer, 2013). An Australian study identified that carers and family members reported improved comfort in their interactions with people living with advanced dementia as a result of Namaste Care (Nicholls et al., 2013).

As yet, no randomised controlled trial evidence has been reported but the approach has high face validity across a number of countries with families and staff. It fits well with expert opinion (Van der Steen et al., 2014) on what needs to be delivered to meet the end of life needs of people with advanced dementia. It is a person-centred approach in line with the most recent national guideline for dementia care (National Institute for Health and Care Excellence, 2006).

Current Research Aims

Introducing Namaste Care into regular care home routines is not straightforward. The authors are leading a three-year implementation study funded by the Alzheimer's Society with the aim of determining an optimal UK intervention based on Namaste Care principles. A starting point for the research was to learn from the experience of those who had already begun to implement Namaste Care in UK care homes. To date there has been no consistent feedback from practice. Knowledge gained from this experience, alongside a literature review of the components of Namaste, will shape the proposed Namaste Care Intervention UK to be tested in the implementation research, as well as identifying issues to be investigated further as part of the research.

Method

A sequential investigation to engage directly with current UK Namaste Care practitioners was undertaken as summarised in Figure 1.

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An online survey was developed covering questions about different aspects of Namaste Care and its delivery. The survey was distributed through multiple channels. Initially, 50 individuals and four care providers known to have an interest in Namaste Care were identified through those who had led training courses and workshops within the UK. The survey was also cascaded via the Contact, Help, Advice and Information Network (CHAIN), by the Alzheimer's Society, Dementia UK and through the study team's distribution lists, websites and social media. The survey was open for four weeks in late 2016, with reminders sent after two weeks.

Survey respondents who had either practiced or observed Namaste Care were invited to participate in an in-depth telephone interview. The interviews aimed to clarify and expand on the survey findings to gain a better insight into the barriers and facilitators experienced when implementing Namaste Care. Topics included the content and frequency of Namaste Care sessions, practicalities, training and support provided, and the impact of sessions. Researchers identified a convenient time for interviews and e-mailed consent forms for completion and return. Three researchers conducted the interviews which were audio recorded and transcribed. Transcripts were thematically analysed (Clarke and Braun, 2013; Vaismoradi et al., 2013; Ayres, 2008) by two researchers who considered various aspects of Namaste Care practice. This part of the study was granted ethical approval by the University of Worcester's Research Ethics Committee.

The survey and interview findings were synthesised with those from the literature review to create a draft Namaste Care Intervention UK. This formed the basis of a practitioner consultation event, comprising three structured roundtable discussions between the research team and practitioners who had taken part in earlier activities. As well as refining and verifying the optimal intervention, the discussions aimed to identify key points of development required in the later phases of the study.

Findings

100 people completed the online survey, with less than half (n=43) having direct experience of Namaste Care (Table 1). The majority of respondents were interested in the approach but had not

directly practiced or observed it. 20 respondents directly practiced Namaste Care and identified as managers and activity coordinators working in care homes. Only four respondents specified that they had a nursing role, but 13 said they worked in a nursing home, hospice or NHS continuing care unit. Respondents who had observed Namaste Care identified themselves as managers and staff working in care homes, hospices, hospitals and people's own homes.

----------Insert Table 1 here----------

Of the 24 volunteers for telephone interviews, 13 took part (Table 2). Six of these interviewees were either working in a nursing role or had a nursing background. 12 practitioners took part in the roundtable discussions including three who had participated in the telephone interviews.

----------Insert Table 2 here----------

There was significant overlap between the findings and feedback from the online survey, interviews and roundtable discussions. These are reported below. It should be noted that not all survey respondents answered every question, so the number of actual responses is indicated where appropriate.

Setting up and preparing for Namaste Care

Many of the survey respondents practicing Namaste Care were new to the role with nine (out of 13) delivering Namaste Care for less than a year. Only three (out of 12) respondents reported receiving ongoing professional support, although a further two indicated that they did not feel support was necessary. Training was regarded as highly important prior to commencing delivery of Namaste Care, but experience of this varied amongst the telephone interviewees. Some practitioners had attended formal training courses, observed Namaste being delivered or read the Namaste Care book (Simard, 2013). Others had not received any training or did not know it was available.

Responses indicated that in some cases Namaste Care is delivered in ways more akin to an activity session for residents than an embedded part of daily care. This suggests a lack of clarity regarding what constitutes Namaste Care and what is a Namaste-like activity. Interviews and roundtable

discussions raised varied opinions regarding Namaste Care participants. Whilst some interviewees focused on people with advanced dementia or at end of life, others felt Namaste Care should be delivered to anyone who 'psychologically needs one-to-one care and attention' (Telephone Interviewee (TI4)) as 'some of our non-dementia residents have gone in and really enjoyed it' (TI5).

Delivering Namaste Care

Three survey respondents (out of 12) reported that they were the only dedicated Namaste Care worker, which is at odds with the whole team approach advocated by Simard (2013). However, six more reported that they were part of a wider team of staff members involved in delivery of Namaste Care. Interviewees also identified that aspects of the team approach were relevant in terms of successful implementation, with training, dedicated time and strong, enthusiastic management sponsorship being powerful facilitators. There was agreement amongst all telephone interviewees, supported by the roundtable discussions, that Namaste Care must be first implemented by those in leadership and influential positions in order to be successful.

With regards to who should be responsible for delivering Namaste Care, some interviewees were of the opinion that all staff should be responsible, whereas others advocated that there should be dedicated roles.

> 'One care home actually used everybody […] used all their care staff, which was absolutely fantastic […] they would have a rota and that worked really, really well.' (TI12)

Namaste Care session locations and group sizes

Survey comments indicated that Namaste Care sessions were held in a variety of spaces: dedicated rooms, communal spaces such as a lounge, or, occasionally on a one-to-one basis in a resident's bedroom. Roundtable discussions raised that practicalities within a care home may dictate where sessions can actually take place. However, most interviewees felt it was best delivered in a dedicated, 'protected' space:

> ‘Something very strange happens around when you, sort of, just allocate a particular room and it's just, it's somehow given more respect, it stays clean and tidy. It's completely magical, there is no real reason for why that should be, but when it's like an everyday space you just don't get the, you don't get that kind of barrier that you open through and walk into that calmer and more peaceful setting’ (TI8)

Sessions were delivered to a maximum of six residents in eight (out of 13) cases reported via the survey, although additional responses suggested that Namaste Care is sometimes delivered to groups upwards of 15 residents. Views expressed by interviewees and roundtable discussions indicated that delivery could be to groups or individuals, but groups with more than 12 residents were less beneficial.

Namaste Care session duration and frequency

Although some interviewees felt that Namaste Care was best delivered with two 2-hour sessions per day and set components, others favoured a more eclectic, ad-hoc, adaptable approach. The roundtable discussions also indicated that if Namaste Care is too prescriptive it could affect implementation by seeming less achievable. Concern was also raised that Namaste Care sessions could become tedious for residents and staff it they were too frequent.

The survey indicated that the prescribed programme of delivering a 2-hour session twice a day for seven days a week was not being followed in many care settings. Eleven (out of 12) respondents delivering Namaste Care reported that sessions lasted less than two hours, and in eight (out of 11) cases only one session a day was delivered. Only five (out of 13) respondents reported sessions being delivered seven days a week.

People who had seen, rather than delivered, Namaste Care sessions expressed a similar view with six (out of 16) respondents reporting one session a day, and the same number reporting two sessions a day. Sessions were delivered seven days a week in eleven (out of 18) cases. Overall, this suggests that rather than being integrated into daily care, Namaste Care in the UK is delivered in a more fragmented way in at least some care services.

Facilitators to implementation

Interviewees expressed that Namaste Care should be supported by a whole organisation approach and led by someone influential, passionate and enthusiastic with the authority to implement change. They identified good communication and education as being fundamental to overcome negative attitudes. The approach was perceived as needing to be underpinned by a working knowledge of person-centred care, and understanding the concept and philosophy of Namaste Care was considered of equal importance to the practical aspects of delivery.

Barriers to implementation

A lack of time, space and resources, and negative staff attitudes were identified by survey respondents as barriers for Namaste Care practice. The interviews reinforced this as the availability, attitude and perception of staff members were seen as threats to successful implementation. For example, one interviewee said, 'everyone is so stretched; so busy' (TI3), with staff often getting 'stuck' in the routine of the day and feeling under pressure. Managers are:

> 'always stuck with the tyranny of the urgent; space, lack of staff, trying to recruit staff to keep the place going, managers haven't got time to think beyond that' (TI3).

Lack of knowledge by other professionals and families was also perceived as a barrier. Those delivering Namaste Care commented that external professionals, including the regulator, seemed to have little information about the approach:

> 'it surprised me that [CQC] took so little interest in it which made me think they've not really heard of it' (TI5).

Equally, interviewees were worried that families could have a negative opinion of the approach:

> '[families] see it as the next step down in the progression […] they saw that people moved from Namaste to die' (TI2).

This perception was, however, counter-balanced by positive stories of family integration into Namaste Care settings.

Perceived benefits of Namaste Care

The survey revealed that, whilst practitioners and observers alike recognised difficulties when delivering Namaste Care, they recommended giving it a go, encouraging people to start small and build up if necessary. Overall, Namaste Care was felt to improve wellbeing and quality of life for people with dementia, having a positive impact on emotional, physical and social aspects of their lives. This included reports that it had a relaxing and calming influence, made people more settled, less agitated, led to a more positive mood and more likely to smile. Respondents also felt it improved skin condition, hydration, weight gain, swallowing and sleep and reduced pain.

From a social perspective, respondents reported a greater sense of inclusion, more interaction between residents, and people were more responsive and communicative. Additionally, practitioners noticed a positive impact from their own perspective as they felt like they were making a difference which in turn improved job satisfaction. More widely, when other care staff saw the impact of Namaste Care for themselves it helped to change their attitude towards the approach.

The culture of the care setting

Although interviewees were not asked specifically to comment on the culture of the care setting, it emerged as a theme in their responses. They said that care staff seem happier and almost relieved as Namaste Care was the type of care they wanted to be delivering:

> ‘people want to do well by people and people care about people, want people to have a good quality of life’ (TI5).

Staff felt proud to be involved in Namaste Care and felt it gave them permission to be able to sit and ‘be’ with a resident.

Interviewees explained however, that acceptance of Namaste Care as part of the care culture would require a paradigm shift as people ‘have got to think differently’ (TI3). There was a feeling amongst practitioners that Namaste Care should be provided as standard at end-of-life but that it was still

perceived as a luxury or additional activity. However, some felt that Namaste Care differs from usual care because it 'focuses the mind' (TI9) and is 'very different from personal care' (TI4).

Discussion

Feedback from the roundtable discussions indicated that participants were generally positive about the draft Namaste Care Intervention UK, finding the overall approach to be comprehensive. Consequently, the proposed Namaste Care Intervention UK was finalised by incorporating the roundtable feedback. The overview of the intervention to be utilised and tested in the subsequent implementation research is provided in Table 3.

----------Insert Table 3 here----------

Responses to the survey and interviews also provided specific lines of investigation for our research. Survey respondents felt that Namaste Care could be appropriate for people other than those with advanced dementia. Additionally, Namaste Care is a relatively new approach in the UK, so inexperience amongst its practitioners would be expected. However, this raises important considerations around the need to support practitioners effectively and how to sustain the implementation of Namaste Care in the long term. Differing views and inconsistencies in mode of delivery also indicate a need for more training for Namaste Care practitioners. This should provide clarity about the focus of Namaste Care, how it integrates with other approaches, and the varied needs of people living in care settings. This is reflected in the three key issues emerging from the roundtable discussions. These will be explored in the next stage of the study through monitoring implementation of the proposed Namaste Care Intervention UK in six case study care homes and are as follows:

1) The parameters of Namaste Care

The frequency and style of Namaste Care required to achieve positive impacts needs to be identified and described more clearly. A high degree of variation currently exists and a lack of clarity could result in important impacts being lost or compromising buy-in from organisations and practitioners. However, any prescriptiveness should be balanced with the need for flexibility and ensuring that the

intervention feels achievable by practitioners. Focusing on the boundaries of effectiveness and the process of getting to 'optimal' implementation in practice would therefore be a useful route forward.

2) The practitioners and audience for Namaste Care

There is a need to clarify appropriate participants for Namaste Care and the best ways in which a staff team can be enabled to deliver it. This must be considered in conjunction with current understanding of change management and culture change in care organisations to ensure maximum success of any implementation. It will also ensure that the unique features of each care home's resident group and staff group are considered, and improvements are driven for the whole home rather than in one specific area only.

3) Training, support and sustainability for Namaste Care

To achieve a consistent approach and ensure the intervention remains rooted in evidence and direct experience, methods for effective training and support for practitioners need to be developed; a challenge for such a disparate and low-resource sector. This will need to occur alongside efforts to raise the profile of Namaste Care and its effects with key care home partners such as regulators and commissioners, so that investment in such an approach by care providers is recognised and rewarded.

Conclusion

Namaste Care is a promising and increasingly popular approach for caring for people with advanced dementia across a variety of care settings. However, current practice in the UK is variable and exhibits a lack of coherence as to method and purpose. Despite this, those with experience of it are overwhelmingly positive regarding its effects and potential. Therefore, further research is needed to clarify the parameters and audience for Namaste Care and to establish the best ways to implement and sustain the Namaste Care Intervention UK. Later phases of the implementation study aim to explore these issues, learning from the experiences of six in-depth care home case studies. These will result in practical guidance for the UK care sector regarding how to successfully implement Namaste Care in a way that is rooted in real-life experiences of care providers and people living with dementia.

Implications for practice

- Development of the Namaste Care Intervention UK should provide a consistent and coherent way to implement Namaste Care
- Implementation of the Namaste Care Intervention UK requires strong leadership
- Training is required for practitioners to ensure appropriate knowledge and support
- The Namaste Care Intervention UK should provide the flexibility to meet the needs of individual residents with dementia

Conflict of interest

The authors have no conflict of interest to declare

References

Ayres, L. (2008). Thematic coding and analysis. In Given, L. (ed.) The SAGE Encyclopedia of Qualitative Research Methods. Thousand Oaks: Sage Publications.

Care Quality Commission (CQC) (2015). The state of health care and adult social care in England 2014/15. Care Quality Commission, London.

Clarke, V. and Braun, V. (2013). Successful qualitative research: A practical guide for beginners. Sage, London.

Corbett, A., Husebo, B., Malcangio, M., Staniland, A., Cohen-Mansfield, J., Aarsland, D. and Ballard, C. (2012). Assessment and treatment of pain in people with dementia. Nature Reviews Neurology, 8(5) 264-274.

Fullarton, J. and Volicer, L. (2013). Reductions of antipsychotics and hypnotic medications in Namaste Care. Journal of the American Medical Directors Association, 14(9) 708-709.

National Institute for Health and Care Excellence (2006). Dementia: supporting people with dementia and their carers in health and social care – Clinical guidance. Available from: https://www.nice.org.uk/guidance/cg42 [accessed 27th March 2018].

Nicholls, N., Chang, E., Johnson, A. and Edenborough, M. (2013). Touch, the essence of caring for people with end-stage dementia: A mental health perspective in Namaste Care. Aging & Mental Health, 17(5) 571-578.

Simard, J. (2013). The End-of-Life Namaste Program for People with Dementia. (2nd ed.) Baltimore, London, Sydney: Health Professions Press.

Simard, J. and Volicer, L. (2010). Effects of Namaste Care on residents who do not benefit from usual activities. Am J Alzheimers Dis Other Dement, 25, 46-50.

Soliman, A. and Hirst, S. (2015). Using sensory activities to improve dementia care. Nursing Times; 111(27) 12-15.

Stacpoole, M., Hockley, J., Thompsell, A., Simard, J. and Volicer, L. (2014). The Namaste Care programme can reduce behavioural symptoms in care home residents with advanced dementia. International Journal of Geriatric Psychiatry, 30(7) 702-709.

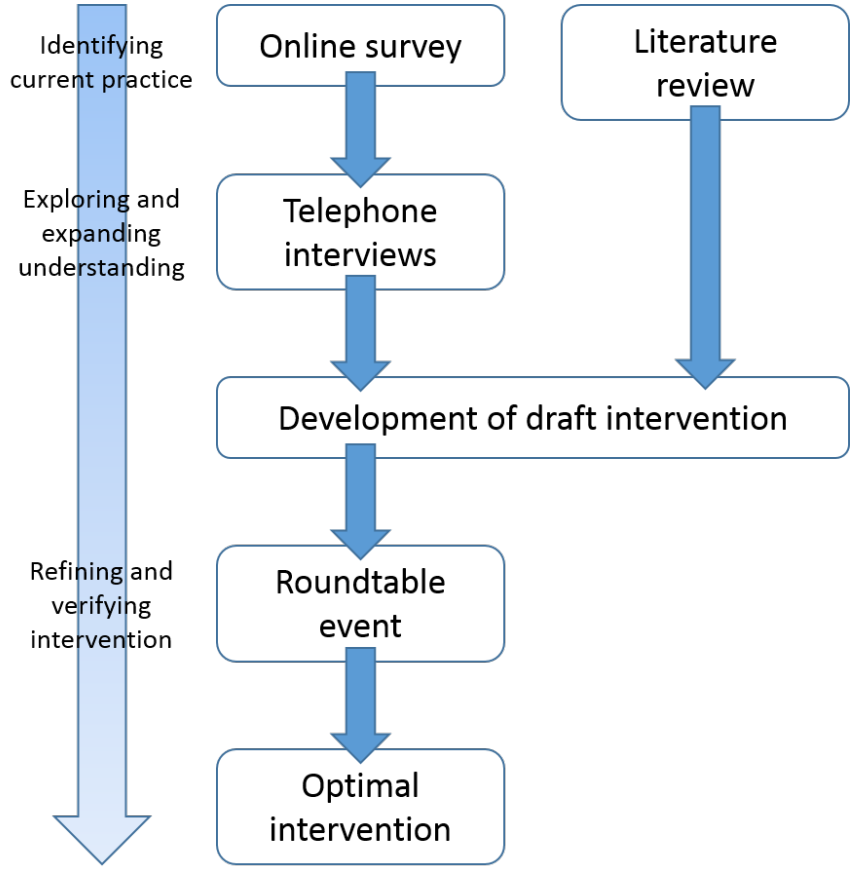
Thompsell, A., Stacpoole, M. and Hockley, J. (2014). Namaste Care: the benefits and challenges. Journal of Dementia Care, 2(2) 28-30.

Vaismoradi, M., Turunen, H. and Bondas, T. (2013). Content analysis and thematic analysis: implications for conducting a qualitative descriptive study. Nursing and Health Sciences, 15, 398-405.

Van der Steen, J., Radbruch, L., Hertogh, C. et al. (2014). White paper defining optimal palliative care in older people with dementia: a Delphi study and recommendations from the European Association for Palliative Care. Palliative Medicine, 28(3) 197-209.

Figures

Figure 1: Overview of activities to explore current UK practice of Namaste Care and development of the optimal UK Namaste Care intervention



Tables

Table 1: Summary of the online survey respondent numbers

	Respondents	Interested in a telephone interview
Practicing Namaste	20	10
Seen Namaste in practice	23	14
Heard of Namaste but not seen it practiced	57	n/a
Total	**100**	**24**

Table 2: Summary of telephone interview participants (including 3 participating in Round Table Event)

Job role	Role relating to Namaste	Area of the country	Length of interview
Assistant Nurse Manager in Nursing Home	Practicing Namaste	West Midlands	20 minutes
Registered Manager of Care Home	Practicing Namaste	East of England	27 minutes
Director of charity working with older people	Practicing Namaste	London	40 minutes
Manager of hospice respite ward	Practicing Namaste	London	36 minutes
Registered Manager of Care Home	Practicing Namaste	Yorkshire and the Humber	26 minutes
Head of Older People and Dementia/Commissioner	Seen Namaste in practice	West Midlands	23 minutes
Admiral Nurse	Seen Namaste in practice	North West England	24 minutes
Self-employed practice development consultant	Seen Namaste in practice	London	43 minutes
Dementia Care Specialist	Seen Namaste in practice	Northern England	23 minutes
Occupational therapist with charitable organisation	Seen Namaste in practice	North West England	29 minutes
Self-employed trainer	Provides Namaste training	Yorkshire and the Humber	62 minutes
Trainer	Provides Namaste training	North West England	43 minutes
Trainer and project lead for charitable organisation	Provides Namaste training and support	North West England	19 minutes

Table 3: The Namaste Care Intervention UK

	Component	Detail
The Namaste Care Space	A beginning and an end	Participants are welcomed individually into a relaxing and calm space at the start of a session. Towards the end of a session participants are activated through changes in the music, aroma and lighting.
	The overall ambience	The space is prepared in advance and attention paid to creating a calm, warm, welcoming and safe atmosphere.
	Natural light and the ability to alter light levels	Strong light levels are avoided, and it should be possible to adjust light levels. Additional atmospheric lighting may be used.
	Specific and calming aroma	Natural aromas are used rather than artificial ones.
	Background sounds or	Gentle and relaxing sounds or music are used to create an

	music	atmosphere rather than providing entertainment.
	Background visual stimuli on a screen	Gentle and relaxing images are used to create an atmosphere rather than providing entertainment.
Basic activities	Physical comfort	Comfortable seating is provided. Pain assessments are undertaken with individual participants prior to sessions. Levels of comfort are monitored throughout.
	Expressive touch	Closeness is communicated using touch, through activities such as hand massage, foot massage, hand and face washing, foot washing, and hair brushing.
	Food treats	Opportunities are created so participants can experience favourite tastes, sensations and textures.
	Drink/hydration	Opportunities are created so participants can experience favourite drinks and ice lollies.
	Tactile stimulation	Opportunities to experience different touch sensations are offered, including soft blankets and fabrics.
	Nature	Opportunities are created so participants can engage with and experience nature such as plants.
Individualised activities	Involvement of the family	Families and visitors are actively welcomed to join the Namaste Care Intervention UK sessions.
	Personalised music	Playlists that are significant to individual participants are incorporated into sessions where appropriate.
	Significant items	Connection and interaction is enhanced by using objects which are significant to individual participants.
	Use of dolls	If participants enjoy interacting with or holding dolls then this is incorporated.
	Use of animals	If participants enjoy interacting with or holding animals (live or toys) then this is incorporated. If in-house or visiting animals are available, these can be included in Namaste Care Intervention UK sessions. Robotic simulations can be used if already available.
	Snoezelen/multi-sensory equipment	If sensory equipment/Snoezelen environments are already available, they can be used in Namaste Care Intervention UK sessions.