



At Home at Selwyn

Creating a regenerative community

A pilot study at Gracedale Home and Hospital
of a model of care based on 'The Selwyn Way'.

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Executive summary

In 2008, The Selwyn Foundation developed and trialled a model of care inspired by the 'Eden Alternative', that would address present and future issues affecting residential aged care. The model was called 'At Home at Selwyn' and was introduced at Gracedale Home and Hospital, Mt Roskill, Auckland, for a one year trial to assess effectiveness and affordability within the New Zealand residential aged care context. The study examined whether residents would be fitter and happier, whether staff had more job satisfaction, and whether the model would be flexible enough to be adjusted to changing demand and cater for different requirements in the levels of care provided.

Results showed a major increase in resident satisfaction, with residents and families more freely sharing their preferences and opinions; an unchanged falls' rate; significantly lowered mortality rates; staff alignment with the vision and values, resulting in a peak of staff turnover; a considerably more satisfied workforce, leading to high staff effectiveness; occupancy at a maximum, and financial results more stabilised and amongst the highest of The Selwyn Foundation.

Background

University research teams and pilot projects supported by the New Zealand government and District Health Boards are developing new ways to deliver better healthcare to ordinary, older New Zealanders. Their efforts are targeted at facilitating older people to age in place, making their own choices about life, such as where to live, and enabling them to enjoy a good quality of life and to receive the support to do so. It is expected that, in the next years, New Zealand will place increased emphasis on homecare; new homecare models have been considered, including 'restorative' home support services that are tailored and aligned to the older person's goals, aspirations and needs. The government hopes this will result in (proportionally) reduced residential care admissions and greater staff retention in frontline home care roles. It is noted, however, that most studies expect an increase in total demand for residential care beds, especially hospital-level beds, due to the vastly increasing number of 'old-old' over the next 20 years.

These considerations reflect the goals of future clients of residential aged care who will be looking for similar restorative care trends when choosing a facility of choice, and for whom the present 'efficient' bio-medical model will be inadequate.

In 2007, The Selwyn Foundation set up a working party to investigate and make recommendations with regard to future care provision. The team - which consisted of members of the Executive, the quality and education manager and a facility manager - recognised that aged residential care appears to be in the centre of a 'perfect storm' as a result of economic and financial pressures, workforce issues, an increased intolerance of imperfection and litigiousness. To date, the aged care industry's conventional approaches to quality improvement and risk management have been ineffective at fundamentally changing our notion of care and the treatment

of the older person. Moving from the 'efficient' biomedical model towards a person-centred philosophy has been less than successful. Nevertheless, a metamorphosis is essential. Residential aged care must become an environment where older people are at home, where family enjoy visiting, staff are respected, listened to and appreciated, where the care is good, life is worth living and legal action is unnecessary.

The “At Home at Selwyn” Project

The Selwyn team listed, investigated and discussed different, exciting models/philosophies of care that would address the abovementioned issues. Its remit was: ***“To develop and trial a model of care that is financially viable; works within the rules of the NZ Sector Standards and the DHB age-related residential care contract; is flexible so that it can be adjusted to changing demands and can cater for different care level needs; and creates an environment where residents are fitter and happier, and staff have more job satisfaction”.***

The Selwyn Foundation Board and Gracedale’s Board agreed in 2008 to pilot what we called the “At Home at Selwyn” philosophy of care. The model was based on the resident-directed/household type model of care in a regenerative community. This philosophy of care could provide the organisation with market differentiation based on The Selwyn Way and Christianity in action. It was expected that improved outcomes in terms of staff satisfaction and happier residents would, in turn, impact positively on the organisation’s financial position and secure its place in the future aged care industry.

Creating a regenerative community means reversing the assumption of decline and substituting a paradigm that emphasizes dignity, choice and growth for residents and employees. We found inspiration in the Eden Alternative Model to develop this vision into a workable model for implementation.

We also found inspiration in the ‘household model’ which creates households or neighbourhoods of residents and staff. It has its own living room, kitchen and dining area, along with individual resident rooms. Combining this with learnings from the Eden Alternative results in a model where care delivery is organised so that the same care staff work in the same household. Activities within a household are organised as similarly as possible to how they would be at home and with a lot of spontaneity. Residents are encouraged to make decisions about their daily life, when to rise or go to bed, when to eat (with snacks available 24 hours per day) and what activities to take part in. Decisions are made as closely as possible to the residents’ preferences, and family members are encouraged to participate in the care. To feel valued, people need to be able to give care as well as receive care graciously; residents are provided with this opportunity by way of caring for plants, pets and by doing simple tasks and, therefore, feel valued members of the household.

Staffing

Particular staff conditions would be needed for the success of the project. The staffing model required staff to work with small groups of residents called a 'household'. Each household has a team leader who has, for a shift, responsibility for the care of the residents of the household. We could consider this person to be the 'Personal Care Coordinator' (previously, 'caregiver'). Further, a household needs a second (part- or full-time) caregiver - or 'Personal Care Worker' and a 'Homemaker' - responsible for the day-to-day running of the 'home', or a combination of a kitchen assistant and cleaner. Depending on the size of the household, these two staff members could have a workload across the households. In addition, there would be a registered nurse who would be available, but not allocated, to a particular household, as well as external service providers who would deliver clinical and other services to the household, residents and staff.

We recognise that registered nurses as well as caregivers really want to make a difference to people's lives, and that is what they most enjoy in their working day. The commitment of staff would go beyond the tasks as allocated to them now, but, rather, would be focussed on the outcomes or impact on residents' quality of life. The Selwyn Foundation already provides the conditions that would make this shift possible. We commit to paying appropriate wages and to providing good conditions, training and support. Input from staff should be sought in issues relating to their work, the client they care for and the programmes they deliver. In return, we expect staff turnover to be significantly lowered. In this model, the relationships are all important and, to that end, we should also support staff through personal emergencies.

Staff were inspired, educated and engaged to participate in the pilot study via presentations and workshops. The purpose of these education sessions was to induce a paradigm shift and reverse the assumption of decline and incapability of older people. Other education was focussed on empowering staff, which had profound effects. For example, harassment prevention education resulted in staff no longer accepting certain types of behaviour in their team. Together with the staff, the manager developed a shared vision of what they wanted achieve. Staff turnover increased initially, possibly due to the culture change.

It was decided not to change staff titles or job descriptions at this stage, but to introduce multi-skilling. Caregivers, cleaners, activities staff and laundry staff were all cross-trained. Staff were very willing, and now caregivers not only provide ADL support, but also look after a household of residents, including setting tables, serving food, clearing tables, cleaning the kitchen and, if needed, working in the laundry.

Households at Gracedale consist of eight residents due to the fact that the architectural layout is such that there are eight rooms in a hospital corridor. At the end of each corridor, there is a kitchen with a large table. This area is now used as the dining area for its household residents, creating a sense of community with residents and staff. Due to the size of the household, which ideally should have been twelve, staff still had to be rostered across households.

Description of the care model for the pilot study

The Eden Alternative (Thomas, 1996) model provides inspiration for an approach that eliminates loneliness, helplessness and boredom from the lives of residents in long-term care, by reintroducing companionship, a sense of purpose, variety and spontaneity into day-to-day experience. Our proposed regenerative model called for the same members of staff to work with the same residents at all times, allowing staff to get to know residents intimately. Staff would then develop relationships and know when something was not right in the world of their resident, and would be given the opportunity to make a difference to the lives of those whom they were caring for. They would provide personal care and medication, but also undertake activities and cleaning, as well as providing meals for the resident. In this way, they would transcend the focus on tasks and duties. Researchers have documented that, in high quality homes, the amount of social engagement between residents and staff, and between residents, is higher and can even be used as a proxy for quality of life (Mor et al. 1995).

Registered nurses are employed as clinical specialists and are not involved in the management of the household. Therefore, they are able to concentrate on assessing the medical needs of the resident and on delivering the required medical care, which is a more efficient use of this scarce resource. A focus on training is needed to assist the frontline staff to make decisions in conjunction with residents, thereby realising the residents' autonomy. The role of the manager is to mentor and empower teams.

The model focuses on residents' and staff control and autonomy, while maintaining clinical standards. Decisions about care and activities in the household would be made with the participation of the residents or, if this was not possible, of the person closest to the resident. Restorative care means that the resident does as much as possible for him or herself, including being motivated by everyday activities and, if need be, some fitness training, both of which improve muscle strength.

Results

To measure the outcomes of the pilot and assess progress, the following performance indicators were monitored:

- a) The aim for 'better outcomes for residents, which would leave them fitter and happier' was measured through the following:
 - resident satisfaction
 - number of complaints from residents and their families
 - falls' rate
 - mortality rate.
- b) The aim for 'staff to have more job satisfaction' was measured via:
 - staff turnover rate
 - staff satisfaction.
- c) The financial viability of the model was evaluated by the following indicators:
 - occupancy levels
 - cash contribution per bedday.

Qualitative analysis was obtained in the form of anecdotes noted by Gracedale's manager (see Appendix).

a) Major increase in resident satisfaction

In April 2008, prior to the start of the pilot, Gracedale had the lowest resident satisfaction results of all of The Selwyn Foundation residential care facilities (based on the annual Resident Satisfaction Survey results). In August 2009 - and twelve months into the project - Gracedale outperformed the Foundation's other North Island facilities on 12 of the 16 sub-questions and on the overall satisfaction question by three percent. Since then, Gracedale continues to be a high performing facility in terms of resident satisfaction.

The introduction of the 'At Home at Selwyn' project had an initial dramatic increase in resident satisfaction, possibly caused by the immediately notable positive changes and the anticipation of a better future. With a few minor refinements, ie, improvements in laundry and enhancing the reception service, there is no reason why Gracedale cannot set its sights on being the facility with the highest levels of resident satisfaction for the Foundation Group.

Residents and families share their opinions more freely

Since the beginning of the pilot project, there has been a significant increase in the number of complaints and an ever steeper rise in the number of compliments. This would confirm that residents and their families are more freely

sharing their opinions about the services they receive. The fact that the number of compliments increased more steeply than the number of complaints may indicate that services have improved.

Falls' rate unchanged

One of the goals of the restorative care model is that residents become more active. We were expecting that this could result, initially, in an increase in the falls' rate of residents, to be followed, possibly, by a decrease in the falls' rate for the same residents, as their muscle strength improved through the increased activity. This was identified as one of the risks of the project at the beginning of the pilot. In fact, the falls' rate per 1,000 beddays at Gracedale has been significantly lower compared with the falls' rate for the whole of The Selwyn Foundation. In 2009, this falls' rate increased only slightly. There did not appear to be a significant impact on the rate of falls.

Mortality rate considerably lowered (against the overall trend)

One of the side effects measured in projects that implement the principles of the Eden Alternative is a decreased mortality rate. We were very interested in whether a benefit of our project (which uses principles strongly inspired by the Eden Alternative) would be a reduced mortality rate. The Gracedale mortality rate was compared with that of another Selwyn Foundation facility - Sarah Selwyn Hospital - to identify if the changing trend was specific to Gracedale or was a general trend. Mortality rate was expressed in the number of deaths per 1,000 beddays.

Sarah Selwyn was chosen because of its similarity to Gracedale. It has a combination of hospital and resthome residents in the same facility, with similar high quality surroundings. Sarah Selwyn has been decreasing the ratio of resthome to hospital beds in recent years. In 2008, the proportion of resthome to hospital-level care beds at Sarah Selwyn was 21.5%, while at Gracedale it was 32%.

Both facilities show a strong, but opposite, trend. While the mortality rate at Sarah Selwyn has an upward trend, mortality rates at Gracedale have shown a noticeable downward trend since 2008, despite a decreased medical/clinical approach as a driver for 'care'.

b) A significantly more satisfied workforce

The introduction of the different way of working - ie, empowering residents and those closest to them, vision-based leadership from the manager and driving for excellence - meant that some members of staff who did not feel aligned with this way of working left their employment at the facility. Staff members were increasingly held accountable for their performance, especially their interpersonal skills. It is felt that, at Gracedale, there is now a stable team of staff who are aligned with the model of care, and it is expected that staff turnover will now

reduce to the level of other excellently performing facilities in The Selwyn Foundation.

To form a picture of staff satisfaction at Gracedale, the results of the August 2009 survey were compared with those of all other residential care facilities in The Selwyn Foundation Group. At Gracedale, all 28 staff members received a survey; 17 surveys were returned (61% response rate) and compared with the 324 returned surveys for all other facilities (57% response rate). The survey was conducted so that the respondent could not be identified. As the number of surveys from Gracedale (17) is relatively small, the results should be read with some caution. On the other hand, one could argue that the results represent the opinion of those staff who felt sufficiently motivated to provide feedback on their job satisfaction.

The staff survey consisted of 15 questions (designed to encompass all aspects of day-to-day work) and a final question: "Overall, how satisfied are you with your job?". The answers were captured in a five-point Likert scale. At the end of the questionnaire, staff could make unprompted comments.

At Gracedale, no staff member said they were dissatisfied with any of the aspects covered by the survey, and nearly half of all staff are 'very satisfied'. Overall, the project has been very positive for staff and has increased job satisfaction. Staff mostly enjoyed the support from their manager and find that they are providing much better care to their residents.

c) A financially viable model

The financial viability of this project was not calculated in terms of return on investment - the project did not involve a financial investment. All staff education, changes in practice and the leadership to drive the project were to be accomplished within the 'normal' workings of the facility, as would be expected for any similar facility. Therefore, the financial measures should be read to establish if the model of care can be implemented and run within the normal/usual cost structure. Improvements to the financial bottom line are expected as a follow-on effect from increased staff stability, reduced mortality and resident turnover, increased census, reduced time spent on complaints, etc. The measures with the biggest and immediate impact on the financial bottom line are staff hours and occupancy.

The financial bottom line of a facility is often expressed in cash contribution per bedday, or income after expenses per bed and per year. The measure is a profit and loss calculation that does not take into account the building's depreciation, but does include all costs for care, equipment and environment. The financial results show that the piloted model of care can be established without a substantial financial investment. Financial return has been stable during the project, and Gracedale continued from the year before to be a financially high performer.

Occupancy at a maximum

Occupancy is the biggest driver for a stable income. Occupancy of a facility depends on supply and demand. Older persons needing residential care, together with their next-of-kin, have a choice when looking for a service provider and, typically, an investigation precedes the choice of care facility. The pilot study was based on the assumption that the proposed model of care better matched the expectations and demands of present and future consumers of residential aged care. If so, demand would go up. Since the start of the project in June 2008, the occupancy rate steeply increased to virtually full capacity at all times. Gracedale, at present, has a waiting list, and prospective residents have been admitted to an alternative Selwyn facility, as they wait for a bed to become available at Gracedale.

Mortality is a second influence on occupancy. Reduced mortality means reduced turnover and a more stable occupancy. We already established that mortality had decreased significantly during the time of this pilot project. Therefore, we are expecting to see more stable occupancy as a result.

A flexible model that will drive future design of residential care facilities

The advantage of a purpose-built household model building is that it can flex with changes in government policy as to the level of care. Our preferred model of care should be ready to drive the building design of future residential services. Gracedale's architecture is a good example of a household model: rooms are arranged in a corridor and each has a living/kitchen area. As part of the project, we looked at what the ideal number of residents to a household would be. The factors that we decided are the most important in determining this number were efficient staffing numbers required for a household and homeliness. The number of residents to one household that the project team recommended was 12 to 13.

Conclusions and Recommendations

Results were, overall, positive and showed a major increase in resident satisfaction, residents and families more freely sharing their opinions about the services, unchanged falls' rate, considerably lowered mortality rates, staff alignment with the vision and values, resulting in a peak of staff turnover, a significantly more satisfied workforce, high staff productivity, occupancy at a maximum and financial results more stable and amongst the highest of The Selwyn Foundation.

Reviewing the results from the study, the project team concluded that:

- the outcome findings are robust and in support of the piloted model of care for residents and for staff
- there were no negative findings
- the staff findings were striking and suggest that staff empowerment is a possible vehicle for improved resident outcome
- implementation issues were around creating a team of staff aligned with the philosophy of care
- financial results were stable and met targets; there are indications that, over time, the model will improve financial returns.

Recommendations for the future:

- to continue analysis for another year to establish the long-term effects of the model
- to use this model in low performing facilities to make substantial changes to the quality of care
- to continue developing the model towards recommendations for the design of future residential care facilities, based on a “household” model of building.

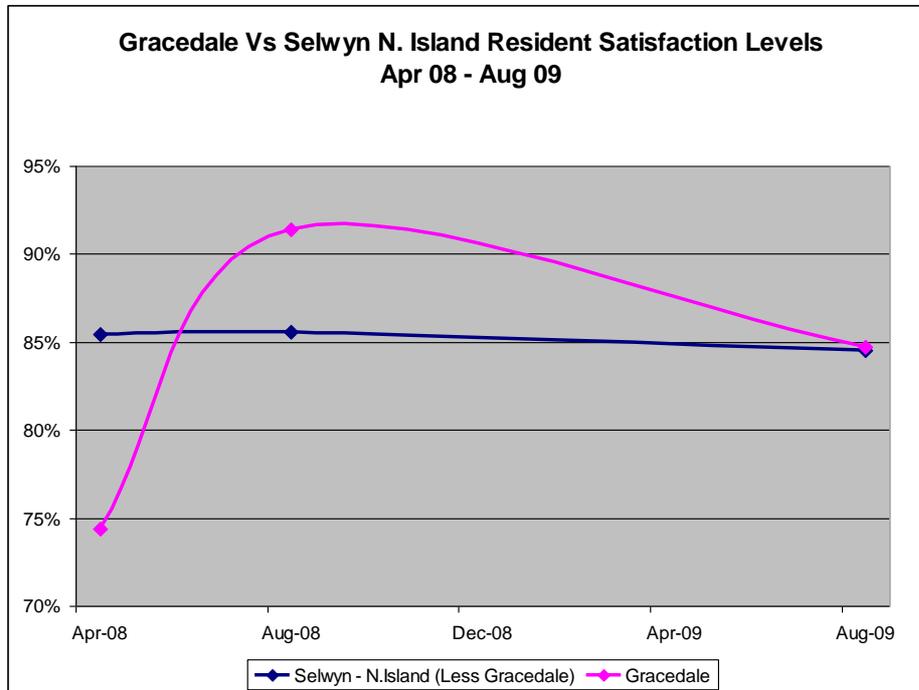
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Appendices

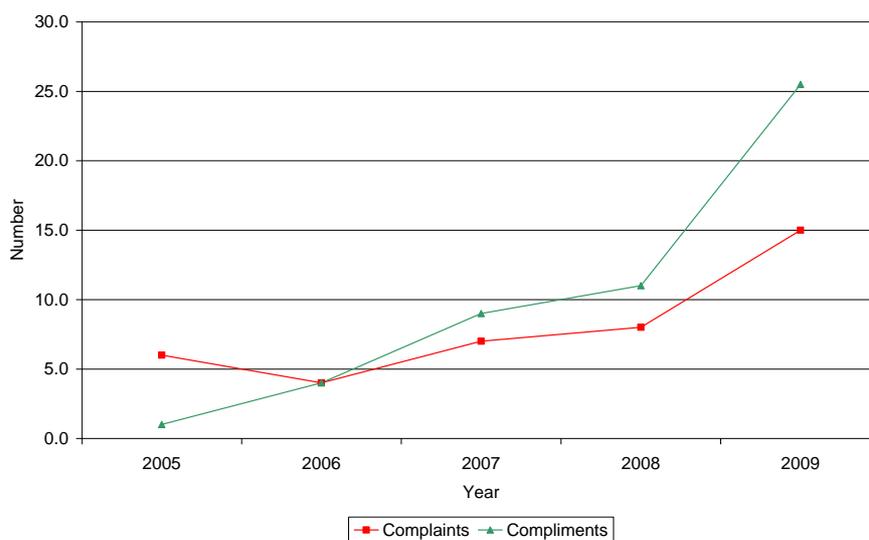
Trended results Resident Satisfaction Surveys, April '08 - August '09

The graph below shows the trend lines of the averaged satisfaction results of Gracedale and The Selwyn Foundation from April 2008 until August 2009.



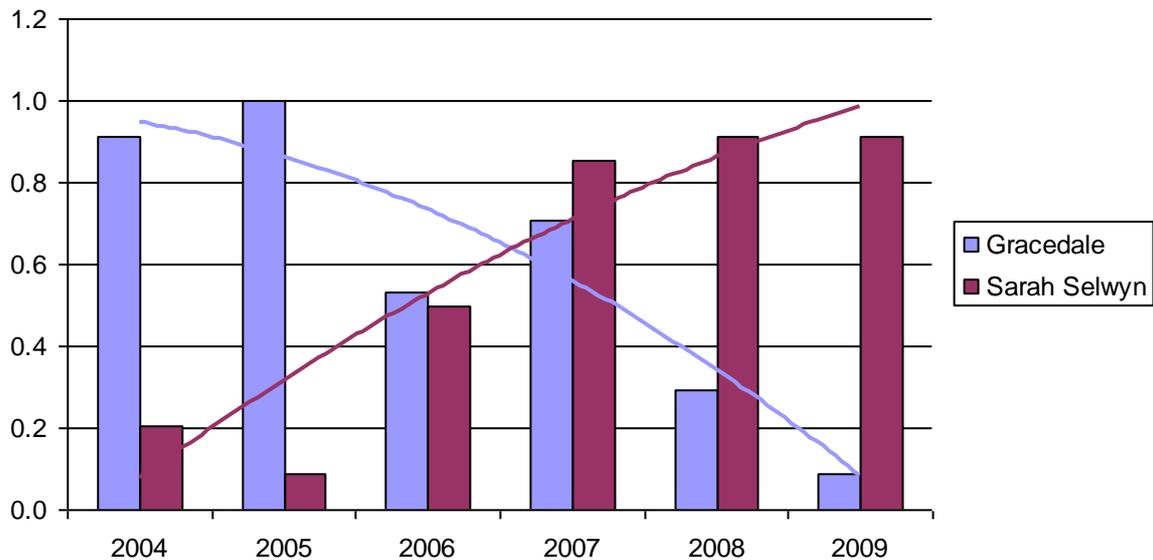
The trend lines show that resident satisfaction, as captured by the Resident Satisfaction Surveys, increased significantly in the initial phase, then leveled towards a slightly higher than average overall satisfaction rate.

Residents and families share their opinions more freely



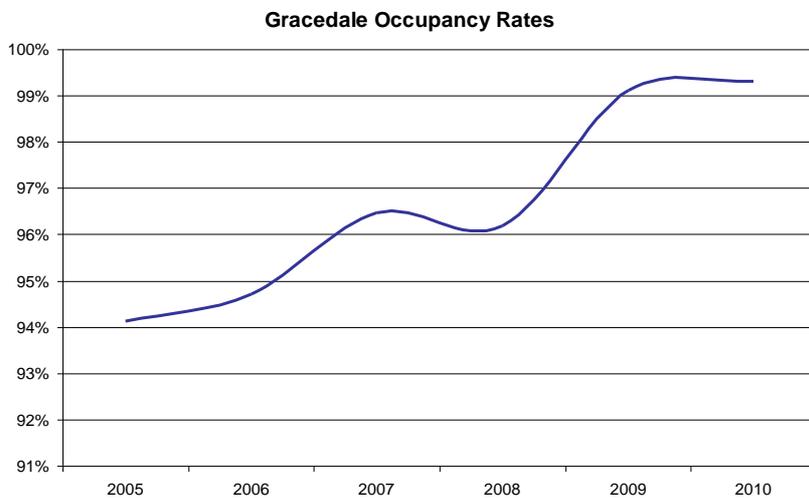
Number of compliments and complaints at Gracedale since 2005

Against the overall trend, mortality rate considerably lowered



Mortality rate per 1,000 beddays since 2004 for Gracedale and Sarah Selwyn, with trend lines.

Occupancy levels, Gracedale 2005 - present



The figure above shows the bed occupancy of Gracedale in the last five years, expressed in the percentage of occupied beds.

Narrative of ‘The most significant changes’

The following is a narrative of the study written in early 2009 by Charmain Diver, Manager of Gracedale, in answer to the question: *What have been the most significant changes since introducing the ‘At Home at Selwyn’ model of care?*

Creating a safe and supportive environment in which residents and staff are empowered to speak honestly about their experiences and their needs.

‘Vulnerability’ is a word that evokes different responses from different people. For me, seeing others who are vulnerable has always brought about feelings of empathy – my awareness of vulnerability in others is what motivates me to be passionate about my work.

As a registered nurse, I was trained to be very aware of the fact that I was going to be the one with all the knowledge, power and health. This had the effect of turning every person I cared for (in my eyes) into less knowledgeable, less powerful and less healthy individuals than me. Whilst developing my personal nursing philosophy during my training, I decided that I would make it my mission to try and maximize and return all the knowledge, power and health that I possibly could to those whom I cared for, and pursue professional accountability within this domain.

I am fortunate to be in a position which allows me to try and take my mission and turn it into a reality for two of the most vulnerable groups of people I have ever had the privilege of working with – the aged adult and those caring for them.

When I assumed the position of manager at Gracedale, after a few months of observation, the two said vulnerable groups had one striking feature in common – they were disengaged from the daily activities of the home and from each other. The care staff and the residents were absolutely focused on their schedules (which revolved around the mandatory care tasks) and their daily routine. Neither of the groups spoke freely to each other about meaningful events and - as I have come to find out after 21 months of careful relationship building - most felt that, if they did, there would be reprisals for doing so from either the manager or a particular registered nurse. The most significant thing for me, though, as I observed the community on a daily basis, was that no-one seemed to be relaxed enough to enjoy their day! Prior to my taking the manager’s role, the care staff had been encouraged not to form personal relationships with the residents – they had been trained to be a task-orientated, respectful and efficient workforce. There was a culture of “doing for” rather than “assisting with”, and the team approach to work was poorly understood and underdeveloped. There was no solid relationship between management and staff, which was possibly due to the high turnover of facility managers (five within

four years). However, the care staff and registered nursing staff were fairly solid in terms of turnover.

As the relationships between myself and my staff developed, I made it very clear that I had an attitude of zero tolerance towards horizontal violence and harassment within the workplace. I had assured the staff that any instances of bullying would be dealt with as a serious matter. This was one of the main points I had made in my very first staff meeting, at which I expressed the desire to work in a harmonious environment which would, in turn, promote a happier workplace in which to support our residents. I explained that I was convinced that excellent care could not be achieved if our willingness to develop as a team was not a priority.

Over time, I was able to restore the staff's faith in the complaints process and sound management – this is something that they had previously struggled with. I continue to try and manage the facility with some key performance indicators of my own which include (but are not limited to):

1. **Transparency** (the staff always know what the important issues are within the facility and what management is trying to achieve and how I am trying to achieve it)
2. **Open door policy** (it's never too far to the top – everyone is welcome in my office for formal and informal reasons)
3. **Zero tolerance for harassment** (There is a zero tolerance from management in relation to any type of ill behaviour towards each other)
4. **Safe, open and honest platforms for our staff meetings** (staff can raise issues without fear of reprisal)
5. **Safe, open and honest platforms for residents' meetings** (residents can also raise issues without fear of reprisal).

It has taken a long time for the caregivers and other registered nurses to regain a belief in the word “team” - finally, they are coming to believe that, together, everyone really does achieve more. However, they also know now that the team is what you make it – and they will only ever get the behaviour that they tolerate from each other.

The most significant change for me is seeing the team develop into one that does not tolerate unhelpful, rude or unsupportive members. Now they speak up because they know they will be listened to. Now that the staff believe that this is the case,

they are able to impart the same sense of security to the residents. I have noticed that the residents are now becoming more vocal about what's acceptable and what isn't, without feeling as if they will be held to ransom about it.

Creating the shared vision: 2007 – 2009: the journey that's shaping our future as an engaged community through partnership and ownership.

My understanding is that, prior to my taking the position of manager at Gracedale in December 2007, the previous managers had developed the facility's "vision" by themselves as a management project. Certainly, in 2007, the manager whom I replaced had formulated the vision as a solo exercise. It was not posted for discussion and, when it had been signed off by the Board members, was not displayed around the facility. Therefore, when I began to ask the staff where they saw us in 2008/2009, they gave me some blank expressions. I tried to explain what a vision was, but, as they had never seen one around, they struggled with the concept. The first vision exercise I put together was fairly simple (so I thought). I put out some forms for the staff to fill in which asked three short questions.

- 1) What do we want to do during the next year?*
- 2) How are we going to do it?*
- 3) Please choose a picture/symbol (I placed a huge selection on a white board and numbered them) and explain why you think these would represent what we are trying to do.*

I didn't get too many responses! I asked several staff whether or not they had ever taken part in developing a shared vision before and discovered that they had not. I expressed my surprise at this and had many, many discussions with people about how important it was that teams develop a vision together. If you don't own it, it won't mean anything and, ultimately, won't be realized. I worked with the responses I had received, though, and spoke about them in the next staff meeting. I put together a vision which tried to encompass some of the key concepts that I had spoken about in relation to the 'At Home at Selwyn' pilot and my recent Eden Alternative training, and went with the "majority rules" picture. I then printed them out and put them up everywhere. I stopped everyone I could and asked them to read it through with me and asked for their feedback. For the next 10 months, the staff got used to me referring to "our" vision and slowly came to understand what it was to have something to work towards that was a shared objective. I was very careful to try and drive the vision away from clinical or financial objectives and to keep it "people and team" orientated.

This year, we have just begun developing our shared vision for the 2009/2010 period and I have received much more feedback and input from staff than I had the year before.

The most significant change for me in relation to this story is seeing the team develop into a dynamic and active change agent which owns the direction it wishes to take. Rather than seeing them work to another's standards or vision, they are expanding and pushing their own. And I've learnt that, as a group, their standards, expectations and visions are possibly higher than my own.

Integrating pets into the facility: Lady Grace and Sir Dale – appealing to people's hearts, not their heads; a “tail” of unselfish risk.

I learnt not so long ago that, by addressing what has been referred to as ‘the three plagues of ageing’ (helplessness, loneliness and boredom – Eden Alternative), older adults in residential facilities can have lives in which they continue to grow. Some of my very learned colleagues had also picked up on such teachings and, together, we felt as if we had a responsibility to spread the word! The antidotes to these plagues were said to be meaningful companionship, spontaneity and being able to have the opportunity to not only receive, but to give care.

One of the most simple ways to introduce these kinds of opportunities (as I thought) would be to introduce some cats for the residents to live with. However, it was not as simple as it sounds. For this concept to work, the residents themselves must want it to occur - much like when you are developing a vision, it has to be a shared experience and one which is wanted. I always thought that the main issue when trying to fight ageism would be trying to get the care staff to understand the concept and then develop the paradigm shift in their minds. Interestingly enough, it was our residents who had the “we're too old” and “we can't do” attitudes. When I first approached them in relation to getting a resident cat in early 2008, I was floored by their negative reactions - the questions they had and the arguments which they put up were almost overwhelming! I think I did a relatively good job in regards to countering the concerns voiced. However, the introduction of a cat – no matter how I dressed it up with talk of “therapeutic environment” and “constant companionship” – was not to happen for many more months. A rethinking of how to get people outside of themselves was needed. It was then I realized that I hadn't appealed to people's hearts and had tried to appeal to their brains!

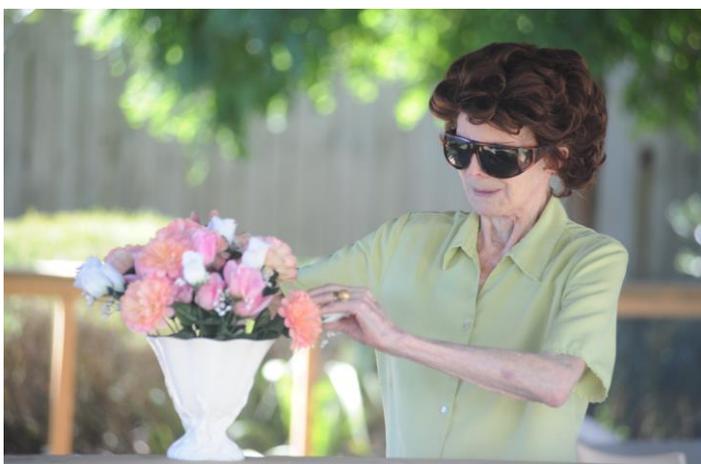
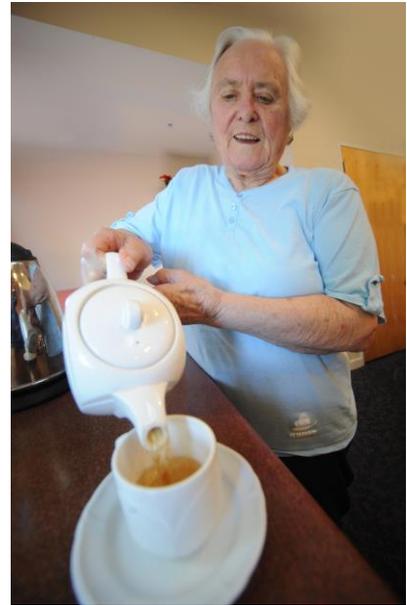
Two days before Christmas 2008, I was fortunate to be offered two kittens with the first year's vet fees, neutering and micro-chipping free! I decided then to pitch the “cat issue” again during the residents' forum in 2009. This time, I told the residents a story... of two little kittens who needed a home, and asked if we could trial them at

Gracedale. I explained that if we could do it for a few months while they were so little, we could get new, loving homes for them if it didn't work out. I also explained that rather than send them to the SPCA – where they would not get the love and affection they would need to be well balanced – I would rather we do it as a community exercise. The residents agreed to give it a go, and any problems that arose were worked through rather easily. They were named Grace and Dale and settled in effortlessly. The most amazing things started to happen. Residents who never left their rooms began to frequent the kittens' feeding area in one of the communal areas once, twice, three times a day! Residents who never spoke to anyone began to speak to strangers in the corridors about the "lovely little kittens" and how adorable they were.

At one stage, the whole facility was up in arms because Grace went missing just after she turned five months old; there were many stories about how she knew that the manager was going to have her spayed so she went out for a bit of fun. The residents were all saying special prayers and expressing their concern to each other about her whereabouts (some even ventured outside for the first time in over two years to call her!). Finally, Grace returned and the residents were celebrating – their prayers had been answered – she was scolded and loved and joked about. The registered nurse who was on duty that night mentioned that, where a medication round would usually take her half an hour, it took her two hours, due to the interest and conversations that Grace's return had provoked.

For me, the most significant change in relation to this story is how people can be motivated by things they first resist. No-one thought that the kittens would benefit the environment. Initially, the matter was being thought about by a group of elderly people in a negative, factual way. When the issue began to appeal to people's hearts, however, that's when the growth occurred.

Residents at Gracedale making themselves at home!



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