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Citation: Thompson, Juliana, Brown, Zoe, Baker, Katherine, Naisby, Jenni, Mitchell, Sophie, Dodds, Christina, Storey, Paul, Tiplady, Sue and Collins, Tracy (2020) Development of the ‘Museum Health and Social Care Service’ to promote the use of arts and cultural activities by health and social care professionals caring for older people. Educational Gerontology, 46 (8). pp. 452-460. ISSN 0360-1277

Published by: Taylor & Francis

URL: https://doi.org/10.1080/03601277.2020.1770469 <https://doi.org/10.1080/03601277.2020.1770469>

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Title: Development of the 'Museum Health and Social Care Service' to promote the use of arts and cultural activities by health and social care professionals caring for older people

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Title: Development of the 'Museum Health and Social Care Service' to promote the use of arts and cultural activities by health and social care professionals caring for older people

Abstract

It is well documented that engagement in arts and cultural activities contributes to improving and maintaining the health and well-being of older people. Despite this, many health and social care professionals do not recognize or accept arts and cultural activities as relevant to their care remit. To address this, a team of 17 individuals comprised of older service users, and staff from a range of health and social care, arts, and museum and archive services in North East England worked collaboratively to design and develop the Museum Health and Social Care Service (MHSCS). MHSCS is a resource and training package that reinforces the care and clinical benefits of arts and cultural activities to older people's health and wellbeing, aimed at supporting health and social care professionals to acknowledge and use these activities as integral to care delivery.

At present, the resource is being trialled in local care homes with health and social care professionals and support staff. This will provide the MHSCS team with information about usability of the resource, and training requirements and effective training approaches needed to use the resource. Subsequent to the trial, the resource and training package will be made available to health and social care providers in locations across the region. An evaluation of staff's competence in, and use of, the resource will be undertaken based on Kirkpatrick's evaluation of learning model.

The MHSCS can be adapted for use in any location and could be adapted to contribute to the care of other patient and service user groups.

Background

It is well recognized that globally, the population is ageing (World Health Organization (WHO), 2015). In the United Kingdom (UK), more than 24% of the population will be aged 65 or older by 2042, an increase from 18% since 2016 (Office of National Statistics, 2019). Many older people live healthy and independent lives. However, many others live with frailty and/or disability, have complex and unpredictable conditions including high levels of cognitive impairment, have limited functional reserve, and are highly dependent (Kingston, Comas-Herrera, & Jagger, 2018; Rohrmann, 2020). Living with these conditions exacerbates risks of social isolation and loneliness, and limits access to meaningful activities (Collins et al., 2020). This can contribute to deterioration or further deterioration in mental, cognitive, social, and physical health (Larsson, Ramgard, & Bolmsjo, 2017; Sjoberg et al., 2017).

Research that considers the health and quality of life priorities of older people living with high levels of frailty and multi-morbidity suggests that their focus is not solely on biophysical aspects, but they also strongly associate quality of life and well-being with social and creative aspects of life such as developing social relationships, and accessing opportunities for meaningful activity (Cooney, 2012; Bradshaw, Playford, & Riazi, 2012). Numerous research and evaluation studies, indicate that engagement in arts and cultural activities can contribute to ageing well and well-being, regardless of individuals' health status (Age UK, 2018; Ali, Gammidge, & Waller, 2014; Coulton et al., 2015; Tymoszuk et al. 2019). For example, Age UK's

(2018) analysis of the relationship between arts and culture participation and wellbeing found that engagement in arts activities is higher among people who report higher levels of wellbeing. Ali et al.'s (2014)'s study of the effects of art therapy on older people with stroke found that the therapy reduced patients' anxiety and had positive physical outcomes when used as a method of rehabilitation. In a randomised control study, Coulton et al. (2015) found that singing improves the mental and cognitive health of older people. Other studies have shown that engagement with arts and culture increases social participation, alleviating loneliness and isolation; and provides a means of engaging in meaningful social activity (Chatterdee & Camic, 2015; Lynch & Alexander, 2016). Some studies propose that engagement in creative activities, particularly those with a goal, boosts older people's self-esteem, and sense of feeling valued, which can contribute to good mental health (Thompson et al., 2017; Thompson, Tiplady, & Cook, 2020).

The positive benefits to older people of engaging with arts and culture have been acknowledged in global health policy and guidelines (WHO, 2019). In the UK, recent health policy recognizes that engaging in these activities in social, community, and voluntary contexts, are methods of promoting and facilitating healthy ageing and improved quality of life (National Institute for Health and Care Excellence (NICE), 2015a; 2015b; NHS England, 2016). Recognition of the health and wellbeing benefits of these opportunities and activities has led to the introduction of social prescribing, defined as 'empowering people with social, emotional, cultural or practical needs to find solutions which will improve their health and wellbeing' (NHS England, 2019).

In the UK, the gold standard approach of assessing the care needs of older people with frailty and complex needs is Comprehensive Geriatric Assessment (CGA). CGA

recognizes that if care is to successfully support improving and maintaining quality of life for older people, it is imperative that all dimensions of health and wellbeing are accounted for (British Geriatrics Society, 2019). CGA requires assessment and support for social, environmental, psychological/emotional/cognitive, and functional needs as well as physical/medical. Assessment and support are tailored to account for the older person's life choices and preferences. Although this requires a multi-disciplinary approach whereby professionals from all sectors use their own professional expertise to contribute to care, they need to work together to 'wrap care around' the older person i.e. the older person is at the centre of the care experience. NICE (2015a; 2015b) proposes that to be successful, it is essential that all professionals involved have an awareness and understanding of all care needs to provide holistic, person-centred care, support choice and preference, autonomy and independence.

As arts and culture are evidenced as providing benefits to all aspects of health and well-being, health and social care professionals, regardless of professional background, should have a level of competence in the use of arts and cultural activities in care delivery. This is acknowledged in the UK by Section 8 of the All-Party Parliamentary Group (APPG) Creative Health Report (2017), which recommends that the education of health and care professionals should include the evidence base and practical use of the arts for health and wellbeing outcomes.

Despite evidence of the strong association between arts and cultural activities, and improved health and wellbeing for older people; and policy and guidance recommending this association is acted upon in care delivery practices, health and social care professionals struggle to use arts and culture in their care. Lehikoinen's (2017) discourse analysis study of four research reports on the use of arts in older

people's care found that professionals in the arts have been forced to justify their work in cross-professional contexts (at the interface between the arts, and health and social care). This is because some health and social care staff do not always recognize or accept the contribution of arts and cultural activities to health and wellbeing. Broome et al.'s (2017) systematic review of the involvement of care home staff in the creative arts found that staff do not perceive the facilitation of arts and cultural activity as part of their professional remit. This impacts negatively on their competence to use these activities to support the health and wellbeing of older people. Thompson, Cook, & Duschinsky's (2017) study of care home registered nurses' experiences and views of their role and status identified that, in response to residents' care priorities (i.e. social well-being and opportunities to access meaningful activities), nurses in social care settings are more likely to engage in activities that support residents' social and meaningful activity needs. However, the study found that this shift in activities away from clinical and medical activities led some participants to question their professional identities as nurses. This is because nurses expect to provide care that is primarily clinically based. When they perceive their clinical practice to be diminished by a propensity for social care needs, they find themselves in a predicament regarding work identity.

Findings from these studies highlight that despite moves by policy and guidance promoting the use of arts and cultural activities in care, many health and social care professionals rely primarily on clinical frames of reference to direct their care and inform their professional identity. This means that they struggle to regard these activities as relevant to their care delivery. An alternative method of supporting these professionals to engage with arts and cultural activities in their care could be to provide guidance about the care and clinical benefits of these activities i.e. bring

these activities within the clinical frames of reference familiar to these professionals. With this in mind, a partnership was developed in North East England involving Tyne & Wear Archives and Museums (TWAM), Northumbria University, Hadrian Healthcare, and Northumberland Tyne & Wear NHS Foundation Trust (NTW) to develop a Museum Health and Social Care Service – a resource and training package to support health and social care professionals to use and value the museum collection as a method of supporting health and wellbeing of older people with complex needs.

This is not an entirely new idea. Equal Arts have developed Recipes for Creative Care in collaboration with care assistants in care homes (Equal Arts, 2019). This resource consists of prompt cards and training on how to bring creativity into care to support multi-sensory communication with residents with dementia. The Cultural First Aid Kit (Gallagher et al., 2019), developed by Manchester University and Whitworth Art Gallery, provides 30 creative activities, which can be incorporated into daily care and rehabilitation care for people with dementia, stroke or mental health conditions. The kit includes the activities resource and a training programme for carers, activity co-ordinators, therapists, support workers and volunteers. Each activity card contains a list of equipment required for the activity, instructions for the activity, and briefly refers to how the activity might support movement, speech or mental wellbeing.

However, to-date, there is little in the way of resources or training that support registered health and social care professionals', as well as carers' engagement with arts and cultural activities by describing the specific care and clinical benefits to older people with complex needs. The MHSCS is unique in that it achieves this, and by doing so, reinforces that these activities are integral to clinical care delivery.

Development of the MHSCS

The MHSCS team

Older people with complex needs are likely to have multi-morbidities and social care needs. Caring effectively for this group of people requires input and collaboration from a range of health and social care professionals to ensure all care needs are identified and expertly addressed. Development of the MHSCS therefore required a collaborative approach with input from a team with a range of expertise in the care of older people. The development team was comprised of 17 experts (table 1).

INSERT TABLE 1 HERE

Table 1: MHSCS Team

Method: stage 1

The first stage of development of the resource involved each team member, except for the museum outreach staff, listing core care needs of older people, and related therapeutic interventions and activities that could support care delivery to address these needs. These were then collated. Some synthesis was required as some of the identified core needs were common to more than one profession. However, it was essential that all professions and experts by experience (EBE) completed this activity in order to maximize the number and range of needs captured.

One team member synthesized the responses and circulated this to other team members for checking. This resulted in an agreed list of 20 care needs requiring support (table 2):

INSERT TABLE 2 HERE

Table 2: Identified care needs requiring support

Related therapeutic interventions and activities were agreed for each core need. Examples of some of interventions/activities related to core needs are shown in table 3.

INSERT TABLE 3 HERE

Table 3: Example of core needs and suggested activities

Method: stage 2

The two team members from museum outreach services and their colleagues from TWAM worked with the agreed schedule of core needs/suggested activities to consider how the museum collection could be used to facilitate care support regarding these needs. The TWAM staff identified a range of activities already utilized by the outreach team, and developed others. A workshop was arranged to which all MHSCS team members were invited. At this workshop, the identified activities were presented to the MHSCS team, and opportunities to engage with and observe the activities were facilitated.

The MHSCS team then documented if, and how, these activities supported core care needs. This approach enabled the team to identify which activities were useful. In total, an initial 15 activities were selected, with a view to adding to the resource collection over time. These activities covered a wide range of topics to accommodate different interests. Local history and culture were embedded in many of the activities as these can support life story work, group discussion, and reminiscence activities.

Method: stage 3

Subsequent to this initial selection, the museum team developed sets of instructions detailing how these activities should be facilitated. The MHSCS team's notes

documenting how these activities support core needs were collated and synthesized by two team members – one museum outreach professional and one healthcare professional, then developed into lists of ‘care and clinical benefits’, each list tailored to each activity. The draft activities’ instructions and ‘care and clinical benefits’ documents were circulated to the team for discussion and comment, then revised and re-revised until agreement was reached.

An example of an activity is ‘Food through time’. This involves collecting together items from, or inspired by, the museum collection that are associated with food preparation during different periods in local history. These items are used to initiate discussion, and then, together with food ingredients, are used to make or prepare food items or meals. The activity’s related ‘care and clinical benefits’ schedule is shown in table 4.

INSERT TABLE 4 HERE

Table 4: An example of care and clinical benefits relating to an activity

Implementation and evaluation plans

At present, the resource is being trialled in local care homes with registered health and social care professionals and care support staff. This will provide the MHSCS team with information about usability of the resource, and training requirements and effective training approaches needed to use the resource. Subsequent to the trial, the resource and training package will be launched at a local conference during Culture, Health and Wellbeing week. Both hard copy resource packs and an online pack funded by TWAM will be made available to health and social care providers.

An implementation and evaluation study will then be undertaken by researchers at Northumbria University. Staff who have used the resource and training package will be invited to participate. As the aim of the MHSCS is to support health and social care professionals to integrate arts and cultural activities within their care delivery, a methodology is required that will determine their competence in, and use of, these activities within their day-to-day care. With this in mind, the proposed evaluation will relate to the four stages of evaluation outlined in Kirkpatrick's (2006) model: Reaction, learning, behaviour, and results.

Reaction is defined by the degree to which participants find the MHSCS resource and training programme favourable, engaging and relevant to their jobs. Methods will measure and explore engagement i.e. the degree to which participants are actively involved in and contributing to the intervention experience; and relevance i.e. the degree to which participants will have the opportunity to use or apply the competencies they have developed. To ascertain information about reaction, a post-intervention feedback questionnaire will be developed and tested by the research team prior to distribution to study participants. The questionnaire will collect data about the impact, relevance and applicability of MHSCS to their competence; and the quality of training provided as part of the project. Focus groups with selected participants will pick up on key themes from the questionnaire and provide an opportunity to add depth.

Learning is defined as the degree to which participants acquire the knowledge and confidence intended by the MHSCS resource and training package. To ascertain information about learning, a comparison study will be undertaken of changes in confidence and knowledge before and after the intervention. A questionnaire will be developed and tested by the research team prior to distribution to participants. The

questionnaire will measure their knowledge of key concepts before and after the intervention, and confidence in applying that knowledge to practice. Focus groups with selected participants will provide further in depth data on the themes arising from the questionnaire findings.

Behaviour is defined as the extent to which the MHSCS is applied in practice and results in changes in behaviour. To determine application of the MHSCS and changes in behaviour, participants will be asked to complete a NoMAD survey (May et al., 2015) to assess the embedding and normalisation of the MHSCS into practice. Data will be collected after three months of the introduction of the MHSCS, after six months, and after 12 months to investigate the sustainability of the use of the MHSCS.

Results are defined as outcomes that occur as a result of the MHSCS intervention. Older people who have participated in the MHSCS activities will be invited to participate by completing questionnaires. These include the Older People's Quality of Life (OPQOL) questionnaire, the EQ-5D-5L questionnaire, and the HowRU questionnaire. The OPQOL has been shown to have validity and reliability in describing and evaluating the multifaceted impact of health and social care interventions on people's lives (Bowling & Stenner, 2011). The EQ-5D-5L and HowRu have been used to reflect measurable differences in older people's experiences that translate into understanding of how care interventions influence quality of care and general well-being (Usman et al., 2018). A sample of questionnaire respondees will be invited to participate in interviews/focus groups to discuss their views about the impact of the MHSCS activities on their lives.

Conclusion

As the global population ages, an increasing number of older people are living with frailty and disability, including cognitive impairment and limited functional reserve. A number of studies indicate that engagement in arts and cultural activities can contribute to supporting these individuals to age well, despite their health status. This has been recognized globally by health policy and guidelines which direct health and social care professionals to use these activities to support older people to engage in social, community, and voluntary activities as a means of promoting and facilitating healthy ageing and improved quality of life. However, many health and social care professionals struggle to use arts and culture in their care because they do not view these being within their professional remit. If arts and cultural activities are to be used more widely to support older people's health and wellbeing, it is imperative that strategies are developed to encourage health and social care professionals to engage with, and value these activities as interventions integral to care delivery. The MHSCS aims to achieve this by providing detailed and specific information about the care and clinical benefits associated with these activities. By doing so, the MHSCS brings these activities within the clinical frames of reference familiar to these professionals, reinforcing their significance and relevance to health and social care. The MHSCS can be adapted for use in any location by using local museum collections on which to base the activities. This ensures activities are relevant to local areas, customs and cultures. Although the MHSCS has been developed as part of health and social care services for older people, it could be adapted to contribute to the care of other patient and service user groups, for example, mental health.

As it is essential to understand the impact on practice and on outcomes for older people, future implementation and evaluation studies will be undertaken.

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Table 1: MHSCS Team

Professional background	Area of expertise	Number of team members
Experts by experience (EBE) – older people with experience of accessing health and social care services	Experience of health and social care services	2
Museum services	Outreach	2
Performing arts	Applied arts	1
Social work	Care of older people	1
Adult nursing	Gerontology	2
Adult nursing	Care home nursing	1
Adult nursing	Use of arts in care	2
Mental health nursing	Gerontology; dementia	2
Physiotherapy	Older people with chronic conditions and chronic pain	2
Occupational therapy	Promoting independence for older people; engagement in meaningful activities	2

Table 2: Identified care needs requiring support

Identified care needs requiring support		
Sensory deficit	Mental well-being	Facilitate choice, preferences and aspirations
Nutrition and hydration	Develop/maintain relationships	Decision-making
Pain management	Loneliness and social isolation	Safety, security and resilience
Mobility and function	Life story work	Financial resources and planning
Reablement and promotion of self-care	Intergenerational activities	
Dementia and cognitive impairment	Care of families/carers	
Health promotion activities	Personal image	
Personal hygiene/infection control	Spiritual	

Table 3: Example of core needs and suggested activities

Core need	Suggested activities
Activities to support nutritional status and hydration	Afternoon tea, social events with drinks/food; cooking/baking
Pain management	Exercise; distraction. Attention/distraction, relaxation. Links with mindfulness, doing activities mindfully.
Accounting for sensory deficits	Use of touch, taste, smell, as well as visual/audio activities. Visual/audio activities that are easy to see/hear.
Dementia and cognitive impairment	Reminiscence; validation; cognitive stimulation Reminiscence/ mindfulness, using activity to stimulate the brain. Confidence building, could run groups and classes based in museums working with other generations passing on knowledge, perhaps with the use of museum items Parkinson's – mobility in a functional way, link between mobility and cognition. Lots of potential with what the museum offers here. What an object is for, function of this, why might use it.
Life story work	Activities to develop life stories eg narratives, significant objects, timelines, collages. Exploring someone's networks/systems through narrative/relationship practice. Enabling someone to talk and explore the people, places and activities important to them.
Mobility and function	Exercise; guided walks; dancing/music. Using in museum workshops and items to assess functionality and increase confidence/ skills. Use museums which generally have good access to aid in health related activities such as mobilising around museums where there are frequent stops and items of interest to have rests and breaks. Activities in standing – objects, holding. Big drive to reduce sedentary behaviour and standing is a great step in this for those who may be unable to do much physical activity. Goal orientated mobility – dementia – 'there's a xxx' – go to look at this - bringing in motor and cognitive elements. Dance and effects of this - growing body of evidence in Parkinson's disease and dementia.

Table 4: An example of care and clinical benefits relating to an activity

Food through time activity
Care and clinical benefits
• The sensory experience associated with food (eg, smell and taste) stimulates memory, cognition and orientation. • Textures, weights and shapes of food during handling stimulate touch. • Preparing, discussing and consuming food and drink promotes hydration and nutrition. • Preparing and discussing food stimulates appetite. • Preparing food promotes upper body movement, dexterity and fine motor skills. • Can be a distraction activity. • Group discussion supports speech and communication. • Food preparation and discussion supports Life Story work. • Discussions about food introduces opportunities to engage in health promotion regarding diet. • For residents interested in food, recipes and cooking, this promotes engagement in meaningful activity. • Group activity and group discussion supports relationship building. • Group activity and group discussion reduces loneliness. • May lead to regular individual or group cooking and/or gardening activities, which will involve standing and walking activities/exercise. • Engagement in meaningful activities stimulates mindfulness. • Engagement in meaningful activities and social activities, and feeling motivated can lift mood, and reduce feelings of depression.