Evaluation of reminiscence activity provided to care settings by museums in Cambridgeshire.

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June 2012

The Evaluators

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Thank you for all the help we received and to all those that gave their time and trusted us with their opinions.

Contents

You have to begin to lose your memory, if only in bits and pieces, to realize that memory is what makes our lives.

Luis Buñuel Portolés

Once you've met one person with dementia... you've met one person with dementia.

Quotation attributed to the late Tom Kitwood.

Executive Summary

This study evaluated reminiscence activity in museums in Cambridgeshire delivered through two projects – Key Memories, which completed in September 2009, and Wide Skies which is on-going. Both of these projects involved the delivery of facilitated reminiscence sessions to care settings. It is this aspect of the projects that is the focus for this evaluation.

Reminiscence involves the use of objects to stimulate conversation about past times. People with dementia retain earlier memories after recent memory has started to fail; reminiscence has the benefit of focusing on what people can remember, rather than on what they cannot. People with dementia can struggle to communicate and reminiscence can provide a 'way in' for carers and relatives, helping them to engage with, and remember, the individual rather than focusing on the disease. The use of reminiscence is not restricted to those with dementia; it can be a pleasurable activity for most people.

There are a number of research studies that have linked positive outcomes to reminiscence work with older people and people with dementia, for example, improved wellbeing and cognition. While only a few of these studies have met the rigorous standards required to establish clinical effectiveness, there is on-going research in this area, including a large-scale study due for imminent publication[1]. This project did not seek to find generalisable proof for the therapeutic effects of reminiscence, but to conduct an evaluation of the two museum projects in light of the wider evidence.

Data for the evaluation was collected principally through a number of semi-structured interviews and three observational case studies; the latter involved the use of a standardised and well-established tool for evaluating provision for people with dementia – Dementia Care Mapping.

The observations took place in two residential care settings and at one day care centre and evaluated participants' reactions to museum-facilitated reminiscence sessions; all of those observed had dementia. Well-being was often high, sometimes very high. Findings from the studies indicate that the highest levels of well-being were noted most often when individuals were actively involved in reminiscing, highlighting its potential. There was evidence of skilled and sensitive practice by museum staff, for example a volunteer discussing war-time memories with a gentleman for whom these were normally traumatic; there was also shared laughter and stories. It was noted that objects that were multi-sensory or promoted action and interaction were particularly successful, for example, dressing-up hats. It was recommended sessions were planned in such a way that participants are able to take control of their own experience by having free access to the objects, rather than being handed them. Staff sometimes needed supporting information about reminiscence objects to help them stimulate conversation.

The ratio of staff to participants was dependant on need. Delivering sessions to

[1] [1] Woods R, Bruce E, Edwards R, Hounsome B, Keady J, Moniz-Cook E, Orrell M and Russell I (2009) *Reminiscence groups for people with dementia and their family carers: pragmatic eight-centre randomised trial of joint reminiscence and maintenance versus usual treatment: a protocol* http://www.trialsjournal.com/content/10/1/64#B38

people with dementia requires higher staff ratios and having adequate staff presence was extremely important, with some individuals requiring one-to-one support. The room set-up and conditions also influenced outcomes; small groups of participants who could interact with each other but, within which there could also be one-to-one support, was one successful model. There was often interaction between participants as well as between staff and participants. One of the case study sessions was particularly successful and observations suggest that the differing levels of wellbeing experienced in the three sessions were attributable to some of the factors outlined above and illustrate the difference that detail can make.

The delivery of sessions is influenced by the care setting who normally select participants and have control over the room choice and set-up. Good prior communication and partnership-working is therefore crucial and it helps if on-going relationships can be established. Inviting care staff to training (as was done) and involving them in sessions is likely to improve the quality of the sessions and assist partnership working.

Interviews with key stakeholders established that almost all of the outputs and outcomes identified for the Key Memories project had been realised – there were some notable successes, for example one care setting believing that it received a more favourable inspection rating due to participation in the project. Most of the museums involved continue to facilitate reminiscence; one museum has embedded the principles of reminiscence within its core practice. A less successful element of the project was that contact between museums and the original care settings they partnered was lost in all cases. Three of these partner care settings did, however, continue to use reminiscence boxes or items that had been provided by the museums. Another area of success was a touring display created in the form of a 1950's kitchen; this was subsequently put on loan to care settings in partnership with Cambridgeshire and Peterborough NHS Foundation Trust, who also use it for training care staff in reminiscence activities. The display continues to be regularly loaned out.

The Wide Skies project had only been recently launched when this evaluation started in October 2011 and reminiscence was small element of the project, however, within several months the project was far exceeding its target for reminiscence. One small, voluntary-run museum for example, had delivered six reminiscence sessions in four months with its volunteers. The project coordinators had, by March 2012 facilitated six sessions with volunteers from five different museums. All these sessions had involved the use of a resource developed for the project: a memory box constructed to resemble a 1950s dressing table.

Training in October 2012 with staff from museums and care settings resulted in reminiscence sessions at two of the care settings that had attended, 60% of those at the training sessions went on to undertake reminiscence activity of some type in the next four months.

The evaluation as a whole identified that museums and care settings value reminiscence and that both believe that museums have a role in providing it; museums were seen as experts in interpreting historical objects. The care settings contacted generally favoured facilitated sessions over reminiscence box loans, and in some instances believed their own staff could learn from watching museum staff and volunteers. An issue for museums is that facilitated sessions in care settings are

resource intensive – the true cost of delivering reminiscence sessions is normally under-estimated where charges are levied.

Reminiscence is usually a positive and rewarding experience for volunteers; one of the most frequently used phrases was about residents' 'eyes lighting up'. By its very nature, however, it can be difficult at times; therefore support and training should continue to be provided to staff and volunteers.

Reminiscence services can be delivered at a number of different levels, from loan boxes, to 'social' reminiscence and reminiscence with those with a high level of need. Not all museums will wish to focus their resources on delivering reminiscence sessions in care settings. Individual museums should realistically look at the cost, effort and their own priorities when considering this issue. Reminiscence activity is, in many ways, a perfect fit for museums wanting to engage with the wider community and can bring tangible outcomes to vulnerable groups. Where it takes place, the involvement of museums with care settings also has the potential to influence practice. Museums have not only the resources to deliver reminiscence, but the volunteers and staff with an interest in people's stories and the knowledge of interpreting objects. The question is, whether museums, especially small, voluntary museums, have the capacity to sustain quality reminiscence services in the longer term, what model they should adopt, and how training and other resources will be funded.

1. The brief and the background

This study evaluated two reminiscence projects run through Cambridgeshire Museums Advisory Partnership (CMAP) and supported by the Heritage Lottery Fund:

- ‘Key Memories: Recollections of My First Home’ (March 2008 - September 2009), a reminiscence project in five small museums funded by the Heritage Lottery Fund.
- ‘Wide Skies’ (April 2011 - March 2014) which aims to encourage and enable volunteers within smaller museums to deliver learning activities; reminiscence work is a one element of this project.

Additional support was provided between the two projects and in the lead-up to Wide Skies through the ‘Priorities Challenge Fund’ in 2009-10. This consisted principally of training and the funding of resources.

The evaluation focuses on reminiscence work involving older people in care settings. It aims to understand critical success factors for museums, to inform future practice and, by evaluating outcomes, provide evidence for current and future funders.

The study, which took place between October 2011 and May 2012 was commissioned by Cambridgeshire Museums Advisory Partnership (CMAP) and has been funded through a grant from the East of England *Effective Museums* programme[2].

[2] Through the government’s ‘Renaissance’ funding stream.

2. Reminiscence

2.1 Background

Reminiscence has been used with older people and particularly with people with dementia since its development in the 1960's. Reminiscence with people with dementia is based on the premise that older memories, from childhood and early adulthood, will be retained after the point when the capacity to 'make' new memories is lost or severely impaired. A factor contributing to its popularity is therefore that it draws on a person's abilities rather than focusing on the illness.

Reminiscence can be used as a way of enjoying nostalgia, to build up a picture of the individual and their life history, to maintain social skills, to deal with difficult feelings of loss and change, to resolve past difficulties and to have fun. For those with dementia it can be an important form of communication:

> *One of the only ways to communicate with people with dementia is to tap their long-term memory rather than talking about what they have just done, which is meaningless to them. [Reminiscence specialist interviewed for this evaluation]*

Isolation can be a particular issue in care settings, particularly for those who are experiencing communication difficulties, such as those with dementia. A study[3] in 2008 by the Commission for Social Care Inspection used an adapted form of the Dementia Care Mapping tool. In 100 thematic inspections involving 424 residents, it was found that 44% of people in the settings did not communicate with others living with them and that engaging with others was related to well-being. It was also found that 22% of people spent time in a withdrawn mood state at a time when other people were engaged with activities – these were people with the most severe communication issues. Its most significant finding was that a 'neutral' communication style was related to poorer well-being scores; neutral communication being *'where staff focus on something that needs to be done and typically lacks empathy and warmth'*[4]. Reminiscence can be used to meaningfully engage those with dementia as it aims to facilitate conversation through the use of multi-sensory prompts and by encouraging those memories that are most likely to be retrievable. Reminiscence as a group activity can encourage interaction between care setting residents. Reminiscence can also facilitate conversation between family carers and resident – something that can be problematic when communication skills are affected.

Reminiscence techniques can vary from informal activity to formal sessions. Ideally it should be embedded within everyday practice when working with people with

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[3] Commission for Social Care Inspection (2008) *See me, not just the dementia: Understanding people's experiences of living in a care home*, Commission for social care inspection.

[4] Commission for social care inspection (2008) *See me, not just the dementia: Understanding people's experiences of living in a care home*, Commission for social care inspection. P11

dementia in order to promote meaningful interaction throughout the day and avoid the 'neutral' communication style – however, stand-alone sessions also have their benefits. Reminiscence can include the use of objects, art, music, poetry and drama and are fundamentally about the use of a stimulus of some kind in order to provoke memories.

2.2 The evidence for reminiscence

Reminiscence is an established tool in the care of people with dementia. What is less clear is the evidence for its effectiveness as a therapy, because while there have been a number of studies looking its outcomes, only a few of these studies have met the rigorous standards required to establish clinical effectiveness. This situation is changing, with new research having been recently completed or in the pipeline.

Researching the effectiveness of psycho-social interventions such as reminiscence is not easy, as the interventions themselves are hard to standardise - reminiscence can be carried out in a number of different ways and involves interactions between people, which are infinitely variable. Another factor is that non-pharmacological approaches do not offer the same potential for profit and that there may be less impetus and funding for clinical trials.

A number of studies have looked at the outcomes of reminiscence therapy for older people, particularly those with dementia, however, as mentioned above, many of these do not use methodological approaches seen as necessary to judge clinical effectiveness (for example, randomised control trials). There have been several reviews to assess the weight of research evidence on reminiscence, including a systematic review for the Cochrane Collaboration[5]. Systematic reviews aim to (i) bring together research studies on a subject (ii) identify those that meet the criteria judged necessary for adequate standards of proof and (iii) examine this body of evidence as a whole in order to come to conclusions about it. Systematic reviews are judged necessary for making decisions about healthcare practice and Cochrane Reviews are generally accepted by the health and social care sector as providing a high standard of evidence. A review of reminiscence conducted by Woods et al (2005) found significant results in relation to cognition and mood, lower care-giver strain and indications of improved functional ability. However, the authors concluded that evidence for reminiscence therapy for people with dementia was inconclusive due to the limited number and quality of studies (they were only able to find four studies for inclusion) and that further research was required. One of the authors has since gone on to point out that there is promising new evidence emerging (trials and Japan and Taiwan) and is himself involved in a large, multi-centre, randomised control trial of reminiscence for people with dementia and their carers[6]. The trial is looking at outcomes such as quality of life for both carer and the person with dementia - this is in due for publication in 2012. A pilot for this project, however, did demonstrate positive outcomes in relation to carer depression and autobiographical

[5] The Cochrane Collaboration is an international organisation which systematically reviews the evidence for the effectiveness of healthcare interventions

[6] Woods R, Bruce E, Edwards R, Hounsome B, Keady J, Moniz-Cook E, Orrell M and Russell I (2009) *Reminiscence groups for people with dementia and their family carers: pragmatic eight-centre randomised trial of joint reminiscence and maintenance versus usual treatment: a protocol* http://www.trialsjournal.com/content/10/1/64#B38

memory interview[7].

A number of pieces of research were not included in the Cochrane review (as they did not meet the methodological criteria for this particular review), for example, a study by Brooker and Duce[8] using Dementia Care Mapping (DCM) as an outcome measure. DCM was used to assess the well-being of individuals in day care provision whilst they took part in reminiscence therapy, in structured group activity (e.g. crafts) and during unstructured time. The individuals' well-being ratings during reminiscence therapy exceeded those recorded during structured group activity which, in turn, exceeded those recorded in unstructured time.

Reminiscence therapy is not confined to people with dementia. In a recent Spanish study[9], 90 people over 65 years, with symptoms of depression but not of dementia, were assigned to reminiscence therapy, or one of two control groups. Those undergoing reminiscence therapy showed an improvement in depressive symptoms, an increase in autobiographical memories and, in particular, an increase in positive memories (the latter outcome, the researchers state, might be partly attributable to the type of the reminiscence therapy used).

Non-withstanding the evidence, there is already much acceptance of the benefits of reminiscence in the medical and care community, for example, the Cambridgeshire County Council guide to Adult Care and Support Service 2011[10] advises checking for activities such as reminiscence therapy when selecting a care home with those for dementia. Reminiscence therapy is also one of a number of interventions recommended within NICE guidelines[11] for those with dementia co-presenting with anxiety and depression.

2.3 Care settings and reminiscence

There is little available data on the extent of reminiscence work in care settings in England; however, research in Wales shows that over 50% of care settings are involved in reminiscence of some sort[12].

A number of care settings were contacted during the course of the evaluation

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[7] Woods, R (undated PowerPoint) *Evaluating reminiscence work in dementia* http://www.tcd.ie/niid/pdf/Evaluating_Reminiscence.pdf

[8] Brooker D. and Duce L. (2000) *Wellbeing and activity in dementia: a comparison of group reminiscence therapy, structured goal-directed group activity and unstructured time*. Ageing & Mental Health, 4 (4): 354-358

[9] Afonso R, and Bueno B, *Reminiscence with different types of autobiographical memories: Effects on the reduction of depressive symptomatology in old age.* Psicotherma, 2010 May:22(2):213-20

[10] Cambridgeshire County Council (2011) *Adult Care and Support Services: The 2011 Cambridgeshire Directory,* Cambridgeshire County Council

[11] National Institute for Health and Clinical Excellence (NICE) (2006). *Dementia: supporting people with dementia and their carers in health and social care.* (National clinical practice guideline; no. 42), http://guidance.nice.org.uk/CG42/QuickRefGuide/pdf/English (viewed 20.1.2011)

[12] Dementia Services Development Centre (DSDC)-Wales: *Services for people with dementia in Wales. Report No. 1: Residential and nursing home care in Wales*. Bangor. 2002.

(eleven), as well as the Dementia Care Service Director for a large chain of care homes. All carried out reminiscence activity of some sort, however, most of the homes contacted also had previous contact with museums for the reminiscence projects being evaluated. The type of reminiscence being carried out varied, in some cases it involved discussions with residents and their families in order to inform a resident's care plan:

> *Not a lot at the moment. The way we do it is we talk to new residents coming in and their families and build up a picture of their earlier lives and what interests and strengths are and record this in the care plan. The main way we use this is to talk about subjects that fit into their background. [Care home member of staff interviewed for this evaluation]*

Other care settings were carrying out more in the way of identifiable initiatives to encourage reminiscence between resident and staff or relatives, this included the provision of rummage boxes, a separate reminiscence room, organised reminiscence sessions, personal memory boxes for residents and themed corridors in order to assist with orientation as well as reminiscing. Staff did not tend to have specific training in reminiscence skills, although they may have had training in related areas (active listening).

> *We use the objects to stimulate conversation. [Care staff]*

Whilst it is difficult to know the extent to which reminiscence is used in care settings from the limited information available, responses indicate that they welcome more contact from museums and support for reminiscence, with all asked wanting further contact with museums. The responses to one museum ringing up care settings within a ten-mile radius showed that they were all open to working with that museum.

2.4 Museums and reminiscence

Museums in Cambridgeshire have been particularly active in delivering reminiscence through the projects covered in this evaluation. It is however, not uncommon for museums to provide reminiscence services and many seem to do so to a greater or lesser degree. This can include provision of loan boxes, training courses and facilitated reminiscence sessions.

Loan boxes may be available from the museum themselves or, sometimes in the case of county museum services, through the library services. Norfolk Library Service for example, has worked with the Museums Service to develop boxes which are loaned out through its normal loans system and which are contained within wheeled suitcases, allowing them to be easily transported. Some of these boxes have long reservation lists, particularly those pertinent to older people, for example a 1940's box which in January 2012 had eleven reservations, and the 1950's box which had seven reservations (in contrast to the 1970s box which had no reservations). The boxes contain instructions and, anecdotally, are borrowed by care staff as well as the public.

One issue in the production of reminiscence boxes can be the provision of suitable material for men. In an innovative collaboration, the Scottish Football Museum has prepared reminiscence packs containing football memorabilia which are available to care settings not only through the museum but through a number of football clubs.

Whilst some loan box schemes are free, in other cases small charges are made to help cover costs; Colchester and Ipswich Museums have adopted a loyalty card which offers every fifth loan for free.

In another approach, Leicester museums facilitate loans through its online ‘Open Museum’, where both artworks and museum objects can be borrowed through its website.

In addition to loan boxes, many services offer facilitated reminiscence sessions. This normally involves a member of staff taking resources out to care settings or social clubs. Some museums, such as Hampshire Museum Service, offer in-house sessions. The latter take place in a hands-on centre, ‘Search’, which has an accessible 20th century room-set; sessions are run along the themes of ‘The Old Corner Shop’, ‘A Great Night Out’ or ‘Busy about the House’.

It is not uncommon for museum services to offer training in reminiscence for carers and support workers. For example, in early 2012 Liverpool Museums (through its House of Memories project) are running 20 workshops throughout the region. Reading Museum loans out its thirty or so memory boxes to health and social care professionals through a yearly membership scheme which includes a place on a training course for one member of staff. The annual cost is £60 per organisation, with additional staff being charged at £40 per person. The boxes are delivered by Reading Mobile Library Service.

3. The policy context

Person-centred practice, with its emphasis on the value of the individual and the importance of creating services around a person's needs and preferences, is the preferred model of care for people requiring support, including those with dementia. The UK government policy from the late 1990's has promoted person-centred care through the development of personal budgets, and other policy landmarks, including *Living Well with Dementia: the National Dementia Strategy 2009.* The growth of person-centred approaches to care and support of people with dementia is compatible with many of the purposes of reminiscence work and is responsible for its inclusion in good practice guidance coming from a range of national opinion formers, despite the lack of clinical evidence at present.

The National Dementia Declaration from the Dementia Action Alliance (2010) is a call to action based on person-centred principles, emphasising the urgency for radical change in a number of areas. It includes general expressions that it is the person's right to be included in their community and be a valued member of it, with choices about how to spend time in a range of ways.

The National Care Forum Statement of *Best Practice: Key Principles of Person-centred Dementia Care* refers to the presence of meaningful activity in the following terms

> *'Enjoyment of, and engagement in life, is crucial to wellbeing and fulfilment. Activity can give meaning and purpose to life.'* [13]

The Health and Social Care Act 2008 modernised the regulatory framework which includes standards of care relating to the welfare of people who live in residential care homes. Regulation 9 of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2010* makes it a requirement on providers of care homes to ensure the

> *'planning and delivering (of) care, treatment and support so that people are safe, their welfare is protected and their needs are met.'*

The most recent updating of those national standards measured by the Care Quality Commission, *What standards you have a right to expect from the regulation of your care home October 2011* affirm the emphasis on individualised care in residential settings.

The promotion of person-centred support has resulted, amongst other things, in a growth of meaningful activity in residential homes, often provided by 'Activities Coordinators'. Of late, best practice would suggest that all staff have a role to play in making all the activities of life have meaning for the people they support, and reducing the task-oriented care which is traditional in residential care.

The Department of Health's call to action (2011) on the reduction of the use of antipsychotic medication because it is an inappropriate and sometimes dangerous way to treat people who are distressed and have behaviour which is difficult to

[13] National Care Forum Statement of Best Practice: *Key principles of person-centred dementia care. National Care Forum Older People and Dementia* Care Committee April 2007

manage, highlighted the use of non-pharmaceutical approaches to treatment, for example reminiscence work. The NICE Dementia pathway: Psychosocial interventions for Comorbid Depression and/or anxiety recommends that

> *A range of tailored interventions, such as reminiscence therapy, multi-sensory stimulation, animal-assisted therapy and exercise, should be available*[14]*.*

Personal budgets have been available to pay for social care for over a decade and are now the government's preferred method of managing the social care budget with a target of 100% take-up by 2013. In the form of direct payments they are not yet available to pay for residential care (this legal anomaly is being addressed by the Law Commission). Personal budgets offer those in receipt of them opportunities to shape their own support and this will have implications for the delivery of reminiscence work in future. Individuals will be able to pay to take part in sessions or have individual work. Collective purchasing, where groups of people receiving a personal budget could pool specific amounts of money in order to pay for group activities may also be possible. Individual reminiscence work, like developing life stories, could also be a feature.

For people whose mental capacity is compromised, decisions about appropriate support which would be enjoyed by the person need to be made sensitively with consultation with the person by those charged with making decisions on their behalf.

For those involved in offering therapeutic activities to those in residential care, the difficulties in providing genuinely individualised care in group settings will have to be addressed as some commentators have noted.

> *How can the individual dictate their social and leisure activities based on their purchasing power, when social activities are delivered and arranged collectively on site?*[15]

[14] NICE Guideline for Dementia: *Supporting People with dementia and their carers in health and social care Clinical Guideline 42.1* developed by the National Collaborating Centre for Mental Health 2006

[15] *Personal budgets alone do not democratise care. Guardian online Claudia Wood Wednesday 19 October 2011* http://www.guardian.co.uk/society/joepublic/2011/oct/19/personal-budgets-dont-democratise-care (viewed 23.01.12)

4. The Evaluation

4.1 Need for evaluation

The Alzheimer's Society predicts rising numbers of people with dementia in the UK due to an ageing population. There are currently 750,000 people in the UK with a dementia with an estimate that there will be over a million by 2021[16]. Whist there is a need for further clinical evidence; research to date indicates the possibilities of reminiscence for providing positive outcomes for people with dementia, and indeed, others within care settings through, for example, increasing well-being and social contact. Reminiscence techniques, it could be argued, are vital for communication with people whose memories are impaired to such a degree that discussion of recent events is all but meaningless

Museums are, in many ways, ideally placed to facilitate some types of reminiscence activity as, fundamental to their work, is the act of interpreting objects to enable people to make meaning from them. There is also a tradition within the museums sector of gathering oral history, which has synergies to reminiscence and life review work. The provision of reminiscence activity of one sort or another is widespread in the museum sector and it will be of use, therefore, to understand how museums can contribute to this practice through evaluating the projects that are the focus of this study.

4.2 Evaluation aims

The evaluation aimed to:

i) Assess the perceived strengths and weaknesses of the projects, particularly key success factors and factors that have enabled progression
ii) Gain an understanding of the scope and effect of partnership working, particularly how museum involvement may add value to the delivery of reminiscence activity
iii) Describe perceived benefits of the project to museums, their staff and volunteers
iv) Describe perceived benefits of the project from the viewpoint of service-users, their relatives, reminiscence facilitators and care setting staff.
v) Estimate the cost of provision per person per hour.
vi) Evaluate current provision using DCM.
vii) Through desk research and discussions with public sector partners and care providers, locate this provision within the current policy framework in the health and social care and local government sectors.
viii) Through desk research, provide a summary of the current research evidence relevant to this project.

4.3 Methodological approach including ethical considerations

The study drew from the framework of 'Process Evaluation' as described by Bliss and

[16] See Alzheimer's Society Website: http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=341

Emshoff[17] , which aims to understand and assess the delivery of a program. In view of the fact that it has a number of broad aims that seek principally to understand a complex and multi-facetted project, rather than to measure quantifiable outcomes, a qualitative approach that incorporates views and experiences of the various stakeholders was adopted. The principal data collection techniques were therefore unstructured or semi-structured interviews, however a standardised tool, Dementia Care Mapping[18] (DCM) was also used to assess three reminiscence sessions within care settings with people with dementia. This was done in order to assess and gain insight into the quality of provision rather than to assess the therapeutic effects of reminiscence.

Alongside DCM, qualitative observations took place in order to provide additional 'richer' data so that the sessions could be described and illustrated for the case studies; they also provided an element of triangulation (whereby data gathered through different methods, for example, is compared in order to understand any similarities or differences)[19]. The qualitative observation was based on a framework for evaluating reminiscence outlined by Hong et al[20]. This mixed-method approach when evaluating provision for dementia is adopted by Sheard[21].

4.4 Ethical considerations

The evaluators complied with the requirements of Cambridgeshire's Research Governance Framework and received ethical approval from the Governance Committee. Particular attention was paid to giving clear detailed information to care home staff and managers and museum staff and volunteers; informing staff and residents before the observations and being available to answer any questions before or after the observed sessions. Highest priority was given to the welfare of the residents.

4.5 Dementia Care Mapping (DCM)

DCM is an established method for evaluating practice with people with dementia, it was developed and regulated by the University of Bradford. All mappers are required to attend an approved training course; in the case of this research the mapping was carried out by an accredited DCM trainer.

DCM is a technique that involves taking observations of individuals in small groups every five minutes. Behaviours are coded (e.g. eating, talking) and the well or ill-being of individuals engaging in these behaviours is scored on a six-point scale.

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[17] Bliss M and Emshoff J (2002) *Workbook for Designing a Process Evaluation* Produced for the Georgia Department of Human Resources Division of Public Health. http://health.state.ga.us/pdfs/ppe/Workbook%20for%20Designing%20a%20Process%20Evaluation.pdf

[18] See http://www.brad.ac.uk/health/dementia/dcm/

[19] Harvey L, McDonald M and Hill J (2000), *Theories and Methods*, Hodder and Stoughton, Oxon

[20] Hong C.S, Heathcote J, Hibberd J (2011), Group and Individual Work with Older People: A Practical Guide to Running Successful Activity-based Programmes, Jessica Kingsley Publishers

[21] Sheard David M (2008), *Enabling: quality of life: an evaluation too'*, Alzheimer's Society.

DCM coding is weighted to the most 'positive' of the observed behaviours occurring, because the aim of DCM is to identify potential, to build upon good practice and encourage person-centred care. The use of DCM for evaluation and research purposes has been described by Sloane et al[22] and by Brooker[23]. The latter concluded that 'DCM has a role in practice development and research within the broad aim of improving the quality of the lived experience for people with dementia' and that 'DCM's advantages are that it is standardised, quality controlled, international, responsive to change, multidisciplinary, and has an increasing research base.' The DCM guidance[24] suggests that it is a suitable research tool for enriching data derived from interviews - although it goes on to state that it can underestimate instances of passive or withdrawn behaviours because of the coding rules.

An issue for the mapping within this evaluation was the short time period during which mapping took place in the case studies. Mapping normally takes place for a six-hour period. DCM has, however, previously been used to evaluate specific interventions such as reminiscence[25].

4.6 Research Framework

A three-tired framework was adopted as follows:

- Tier 1 (Overview): Gaining an overview of the projects covered by the evaluation, developing 'logic maps' of their intended outputs and outcomes and identifying key players. Estimating the cost of provision.
- Tier 2 (Retrospective) Evaluation of the Key Memories Project, which finished October 2009 (Key Memories) and its legacy.
- Tier 3 (Assessing current provision): Assessing on-going reminiscence work in the 'Wide Skies' project through case studies, each involving an observation.

4.7 Sampling

It had been planned to conduct two case studies for the retrospective part of the study (Tier 2); the cases would be selected in order to best meet the evaluation aims (purposeful sampling[26]).

It became apparent that each of the five museums involved in the retrospective project (Key Memories) had very different and potentially useful experiences. Due to the lapse of time since the completion of the project, a number of individuals involved had moved on (especially volunteers and care setting staff). In some cases,

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[22] Sloane PD, Brooker D, Cohen L, Douglass C, Edelman P, Fulton BR, Jarrott S, Kasayka R, Kuhn D, Preisser JS, Williams CS, Zimmerman S*., Dementia care mapping as a research tool*. International Journal of Geriatric Psychiatry. 2007 Jun; 22(6): 580-9. P.17

[23] Brooker D, Dementia (2005) *Dementia Care Mapping: A Review of the Research Literature*, The Gerontologist, Vol. 45, Special Issue I, 11–18

[24] Brooker D and Surr C (2005) *Dementia Care Mapping: Principles and Practice*, University of Bradford

[25] Brooker, D. and Duce, L. (2000) Wellbeing and activity in dementia: a comparison of group reminiscence therapy, structured goal-directed group activity and unstructured time. Ageing & Mental Health, 4 (4): 354-358

[26] Bryman A, (2004), *Social Research Methods*, Oxford University Press

memories of the project were also a little hazy. Data was therefore gathered from all five museums involved (and care setting partners) rather than from two case studies.

All available individuals that had been involved in the Key Memories project were contacted; where care staff had moved on, the organisation was spoken to in order to understand the legacy of the project.

In terms of the three case studies to evaluate current provision (Tier 3), two of these took place in residential settings and one in a day care setting. These were selected purely on the basis of availability; in the case of the two latter case studies, while these were part of the normal activity for the museums, one was bought forward for the evaluation and the other put on especially. This was due to the lack of reminiscence sessions during the short evaluation period and a period during which ethical approval was being sought and during which the observations could not take place.

In addition to the case studies a number of other informants were contacted in order to build up a picture of reminiscence work more generally and gain a picture of partnership working. A list of informants for all the tiers of the study can be found in Appendix 1

4.8 Data analysis

The DCM analysis was carried out according to the principals set out in its guidance[27].

Qualitative data was sorted into broad categories which were refined into themes as analysis progressed. Whilst the data collection process was influenced by emerging findings and was therefore somewhat iterative, it was a process broadly guided by the aims of the evaluation; the categories arrived at in analysis were therefore often similar to these aims. Within these parameters however, the findings arose inductively from the data.

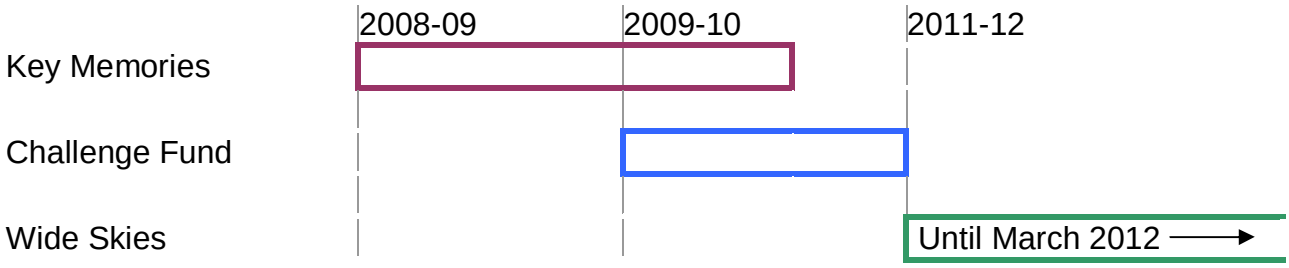
[27] Brooker D & Surr C, *Dementia Care Mapping: Principles and Practice*, University of Bradford, (2005)

5. The Projects

5.1 Overview of the projects covered by this evaluation

This evaluation investigates reminiscence work with older people in care settings through the following projects: 'Key Memories: Recollections of My First Home' which finished in September 2009 and 'Wide Skies' which commenced in April 2011. Both of these projects are Heritage Lottery Funded. Additional support was provided through the 'Challenge Fund' in 2009-10, which funded reminiscence training, support and resources in the lead up to the reminiscence element of the Wide Skies Project.

Fig 1: Timescales of projects covered in this evaluation



The projects are explained in more details below, however in brief:

Key Memories: Recollections of My First Home was an intergenerational reminiscence project around the theme of 'My First Home'. It involved five museums in Cambridgeshire developing resources and delivering reminiscence sessions in a care setting in their area. Whilst small, all these museums have some paid staff.

The Challenge Fund provided support for the development of memory boxes in three museums, training sessions, the development of a leaflet and the production of two reminiscence resources (scaled-down, replica dressing tables containing reminiscence objects) to be used in reminiscence sessions by Wide Sky Museums.

The Wide Skies project is principally concerned with the training of volunteers in small, volunteer-run museums in order to improve education and learning provision. Reminiscence is a small element of this project. There are nine museums in Wide Skies, grouped into two clusters. Each cluster is led by a part-time project worker based in a bigger 'lead' museum that has paid staff - both of these lead museums were also involved in the Key Memories project.

5.2 Key Memories: Recollections of My First Home

The Key Memories: Recollection of My First Home involved five museums (one from each of the Cambridgeshire Districts) each of whom had service-level agreements with CMAP. The key aim was to develop intergenerational reminiscence work; this was to be done through training, support and funding to enable staff and volunteers in each museum to:

- Develop a reminiscence resource (reminiscence box) around the theme of 'My First Home' using their reserve collections
- Develop a partnership with a care setting in their area and deliver five reminiscence sessions at the care setting using the resource
- Deliver an intergenerational reminiscence session based on the theme of 'My First Home' with the care settings and residents of newer communities
- Provide a reminiscence resource (box) to the care settings whose staff would also be trained in reminiscence skills
- Collection of a number of oral history records

- In addition, funding allowed for the development of a travelling exhibition on the theme of 'My First Home' that could tour care settings and museums and further promote reminiscence.

The project focused on the 1950's as this was the period that many older people within care settings would have been setting up their first home. It was coordinated by CMAP and a lead was identified in each of the participating museums; in some instances this was an external freelancer. A freelance reminiscence specialist was employed to deliver training, help museums developing reminiscence resources and give support to museums in organising and delivering reminiscence sessions. This role therefore could be said to have involved an element of project management.

Intended outputs and outcomes and how they have been met:

- The intended outputs and outcomes of the project have been extracted from the HLF bid for the project and are summarised in the 'logic map' below
- The following page gives a simplified assessment of how outputs and outcomes have been met.

Note: *The focus of this evaluation is the experience of reminiscence with older people in care settings, the Key Memories project, however, also involved intergenerational work and oral history collection - oral history is not included on the logic maps, intergenerational work, which included some reminiscence is included in italics*

Key Memories: What was meant to happen?
Simplified from HLF Bid, oral history element not included, intergenerational elements included in italics

INPUTS Resources and funding	OUTPUTS Activities the funding enabled	OUTCOMES Intended benefits in the short, medium and longer term		
Support from CMAP Funding from HLF Support from management at five participating museums Volunteer time Co-operation of care setting management and staff	Reminiscence training for museum staff and volunteers enable them to gain skills. Funding/support to enable creation of reminiscence resources based on 'My First Home' in each museum using reserve collections Funding/support to create a 'My First Home' travelling exhibition Support from reminiscence specialist to assist the delivery of reminiscence sessions Reminiscence training for care staff.	Each museum forms a partnership with a care setting and community group Each museum delivers 5 reminiscence sessions at each care setting using resource (*Each museum delivers an intergenerational session at partner care setting)* Each museum supplies reminiscence resource to partner care setting Touring exhibition tours a range of care settings and museums	Increased access to reminiscence for older people in care settings. Increased access to reserve collections and heritage for older people in care settings. (*Older people in care settings and younger people from the local community brought together)*	Continued access to collections, history and heritage and to reminiscence through: On-going use of reminiscence by staff and volunteers at museums including the use of the memory boxes On-going use of resources and reminiscence in care settings involved. Continued touring exhibition

ii) Key Memories: How did it deliver?

INPUTS Resources and funding	OUTPUTS Activities the funding enabled	OUTCOMES Intended benefits in the short, medium and longer term		
Support from CMAP Funding from HLF Support from management at five participating museums Volunteer time Co-operation of care setting management and staff	Reminiscence training for museum staff and volunteers ✔ Creation of resource using reserve collections ✔ : **resources created but mostly not from reserves** Funding/support to create a 'My First Home' travelling exhibition ✔ Support from specialist to assist the delivery of reminiscence sessions ✔ Reminiscence training for care staff. ✔	Each museum forms a partnership with a care setting and community group. ✔ Each museum delivers 5 reminiscence sessions at each care setting using resource ✔ **: except 1 museum** (*Each museum delivers an intergenerational session at care setting*) ✔ **: except 1 museum** Each museum supplies reminiscence resource to partner care setting ✔ Touring exhibition tours a range of care settings and museums ✔	Increased access to reminiscence for older people in care settings ✔ **: probably although hard to baseline** Increased access to reserve collections and heritage for older people in care settings ✔ : **Access to newly acquired collections rather than reserve collections** (*Older people in care settings and younger people from the local community bought together*) ✔ **: a little mixed, one notable success**	Ongoing use of reminiscence by staff and volunteers at museums including the use of the memory boxes ✔ **In 4 settings although amount varies; relationships with partner care settings not maintained** On-going use of resources and reminiscence in care settings involved. **Limited** Continued touring exhibition. ✔

UNEXPECTED OUTCOMES: A partnership was developed (and continues) with Cambridgeshire and Peterborough NHS Foundation Trust who, after the end of the project, started using the touring displays when training care setting Activity Coordinators.

The project developed differently at each of the museums, with each having particular strengths and weaknesses. The following briefly explains the schematic above assessing delivery

- Partner care settings were found by each museum and at least five reminiscence sessions were delivered by four of the five museums involved. One museum did not achieve this as a member of staff left (one session was delivered), however a freelancer was bought in and conducted two day-long, oral history sessions at a community centre instead.
- Resources (reminiscence boxes) were developed by all of the museums, including a resource to be passed on to each of the care settings. Four of the five museums continue to use their box, however, these are rarely borrowed as stand-alone resources by care settings, who appear to prefer to have facilitated sessions. It may be that some care setting need instructions on the use of such resources, or that more publicity is required.
- Most of the museums acquired new objects for their boxes. This was because museum collections are not always relevant to the theme in question, are too precious or delicate. Only one museum made any real use of reserve collections, however in some instances paper collections e.g. photos, programmes were copied and used.
- All museums recruited volunteers in addition to project leads, (at least one per project) these assisted with putting together resources or delivering reminiscence sessions. One of these volunteers is still routinely involved in delivering reminiscence.
- Most of the museums (four out of five) still carry out reminiscence sessions, in three of these there is a direct link to staff or volunteers involved in the Key Memories project. Progression has occurred where there are staff or volunteers with an interest and ability to continue the work. The work did not continue in one museum where both the project lead and volunteer left. The number of reminiscence sessions currently carried out by each museum is not great (normally one every other month or so, but around twice a month in one of the museums); however, in small museums there is limited capacity to deliver this type of work. Roughly half these sessions are delivered as ‘social’ (rather than therapeutic) activity, for example, to pensioners groups.
- One museum has gone on to integrate reminiscence and memory in its broadest sense into much of what it does e.g. in exhibitions, outreach and events.
- Whist not the focus of this evaluation, one of the intergenerational projects deserves mentioning, as it was clearly perceived as very successful by many, including inspectors visiting the home. It was felt by the home in question that this activity resulted in it getting an additional star in its inspection.
- Reminiscence boxes donated to care settings remain in active use in two cases; one of these care settings loans its box to other organisations. Both of these care settings had a strong, pre-existing practice of using reminiscence, which may explain why the boxes have continued to be used. A further setting has used a specific item from the memory box given to it.
- There has been no on-going contact between museums and the care settings

they worked with; the care settings were, however, without exception, interested in working further with the museums, demonstrating the demand for this service. The care settings seemed to place the onus on the museums keeping in touch, however, the museums also talked of difficulty in focusing on this type of work because of competing demands.

- The travelling display (1950s Kitchen) was, and remains, extremely popular with care settings and is still in regular use (although the CMAP Partnership Officer did put a lot of effort into promoting it). It is also used as a training tool in sessions for Activity Coordinators delivered by Cambridgeshire and Peterborough, NHS Foundation Trust, where there was, at one point a waiting list for its use.
- There was positive feedback from museums involved on how the project was run

"Inspired idea and the whole thing was brilliantly run'

The Kitchen Cabinet

5.3 Wide Skies and the Challenge Fund

The Wide Skies project is principally concerned with the training of volunteers in small museums in order to improve education and learning provision. Reminiscence is a small element of this project.

There are nine museums in Wide Skies, grouped into two clusters, each cluster is led by a part-time project worker based in a bigger 'lead' museum - both of these lead museums were also involved in the Key Memories project. Apart from the two lead museums and one other, none of these have paid staff (they are all volunteer-run).

Intended outputs and outcomes
Reminiscence is a small element of the Wide Skies project it is expected that across each cluster of museums one reminiscence session per month is delivered However, the main body of the HLF bid, concentrates more broadly on enabling learning and outreach activities through the recruitment and training of volunteers. Reminiscence activity delivered by volunteers does however fall broadly within this remit and helps deliver many of the outcomes and outputs outlined in the bid. The relevant outputs and outcomes have therefore been extracted from the HLF bid for the project and are summarised in the 'logic map' below.

The Challenge Fund

A further funding stream, the Challenge Fund, has enabled training and resources to be developed, some of which are contributing to the reminiscence element of the Wide Skies project. It funded three training sessions, the development of two reminiscence boxes based on a scaled-down model of a 1950s dressing table developed after consultation with care setting staff, reminiscences boxes for four museums, it also provided individual support for three museums. A leaflet outlining reminiscence resources in Cambridgeshire museums has also been produced.

1950's Dressing Table

Some of the contents

i) Wide Skies: outputs and outcomes relevant to reminiscence

INPUTS Resources and funding	OUTPUTS Activities the funding enabled	OUTCOMES Intended benefits in the short, medium and longer term		
Wide Skies Support from CMAP HLF funds for co-ordinators etc Support from two lead museums & other seven museums. Volunteer time Co-operation of care setting	Reminiscence training for museum staff and volunteers enables them to gain skills. Support from coordinators enables museums to make new partnerships with care settings. Support and facilitation from co-ordinators to enable reminiscence sessions to be delivered. Care staff trained in reminiscence skills	Increased awareness of reminiscence resources available in Wide Skies museums Wide Skies Museums deliver reminiscence sessions to care settings using dressing up table resources (target half day per month across project). Care staff work with museums to facilitate reminiscence these sessions and participate where appropriate. Loan boxes resources are used in reminiscence sessions or loaned out	Increased reminiscence (therefore access to / engagement with collections for the elderly Improved wellbeing for elderly people taking part in reminiscence sessions or using loan boxes. Carers for people with dementia benefit through increased availability of positive activities. Museum staff and volunteers acquire skills and /or have experiences that they value.	Increased community understanding of local heritage and the benefits museums offer to local people Increased awareness of the scheme and its benefits. Continued pool of volunteers Continued relationship with care settings and other partners On-going use of resources and reminiscence in care settings involved. Continuation of reminiscence activity
Challenge fund Funding from challenge fund to enable resources to be developed	Replica reminiscence dressing tables (x2) Reminiscence boxes support and training to March Museum, Ramsey Rural Museum and Denny Abbey Leaflet on reminiscence Three training sessions			

The Wide Skies project is still in its early stages so no attempt has been made to assess how it has met it outputs and outcomes; even so there have been a number of achievements to date.

- Reminiscence is a small part of this project overall, however, both coordinators are actively involved in promoting and brokering reminiscence activity, The target of half a day a month reminiscence across the project is, so far, being exceeded They have facilitated six sessions between them involving volunteers from five different museums. All these sessions have involved the use of the Challenge Fund dressing table resource.
- The sessions have been written up engagingly in the Wide Skies Newsletters, along with photos, in order to share practice and encourage other museums.
- The reminiscence training session held in October 2011 involved both museums and care settings. Two of the three care settings represented have since held reminiscence sessions with museums (in both cases this was facilitated by the Wide Skies Coordinator). Whist both care settings were more generally familiar with reminiscence techniques, the practice of using objects in organised sessions of this sort was new to them. Both expressed a wish for further contact with museums.
- Individuals who attended this training session and have responded to follow up enquiries have all since been involved in reminiscence or have plans to do so (around 60% of attendees).
- One small, volunteer-run museum, in the space of a few months has carried out six reminiscence sessions, four of these repeat visits at one care setting. Delivering reminiscence activity is resource intensive and this is quite an achievement.
- Another museum has undertaken an innovative approach to developing its reminiscence boxes through the use of intergenerational techniques and by involving older people in day care settings in their development. These memory boxes have not yet been used but it will be interesting to see how successful they are since they have, to a degree been, ‘co-produced’ by their intended audience - this approach is one that ties into ideas of participation in service development.
- A further museum has expressed an interest in integrating the theme of reminiscence and memory into its provision more generally. This has similarities to the approach adopted by the Folk Museum in the Key Memories project.

6. Reminiscence Case Studies

Three of reminiscence sessions run through the Wide Skies project were observed and case studies written up; two of the sessions took place in residential care homes and one in a day care setting. Sessions were observed by two evaluators, one of whom used a standardised observation tool, Dementia Care Mapping (DCM). This uses pre-set codes to map types of activity and measure wellbeing; a short narrative report is also produced to illustrate findings and make recommendations (see section 4.5 for further information about DCM). A second evaluator undertook a qualitative observation (i.e. not using pre-set codes) of the same groups of residents using a framework suggested by Hong at al[28]; this evaluator also conducted semi-structured interviews with museum staff and volunteers and care staff involved in each reminiscence session. In each case only 3-4 participants were observed (as this is the practice within DCM).

The case studies are written up below, starting with charts showing the DCM results. These are followed descriptions of the sessions taken from the qualitative observations and the DCM, interview findings and recommendations from the evaluators.

6.1 Dementia Care Mapping: The results

During a mapped session of DCM, the mapper records coded scores for each individual being mapped every five minutes. These codes represent two types of data – well/ill-being scores (also called 'ME values') and activity codes. Activity codes describe the types of activities residents are engaged in and can include passive 'disengaged' activities as well as what could be described as more potentially positive, engaged ones.

Behaviour (Activity Codes) observed in this evaluation
In DCM, the Activity Codes describes up to 23 different types of behaviour that has occurred during a 'map'. Ten activity codes which were observed in the maps that took place for this evaluation are explained below.

A = Articulation: interacting with others, holding a verbal or non-verbal exchange with no obvious accompanying activity.

B = Borderline: the person was engaged, but passively watching what was going on around them rather than being actively involved 'doing'.

C = Cool: the person was disengaged, and showing no interest in others or the surroundings.

D = Doing for Self: engaging independently in any activity relating to self-care e.g. cleaning spectacles.

E = Expressive: engaging in an expressive or creative activity.

[28] Hong C.S, Heathcote J, Hibberd J (2011), *Group and Individual Work with Older People: A Practical Guide to Running Successful Activity-based Programmes*, Jessica Kingsley Publishers

F = Food: all aspects of the person eating and drinking either independently or with assistance, in this case from cups of tea and coffee already on the table.

G = Going Back: engaging in reminiscence or life review, in this case facilitated by being in a structured group using objects to prompt memories of past times and personal life stories.

K = Kum and Go: a participant walking, standing or moving independently.

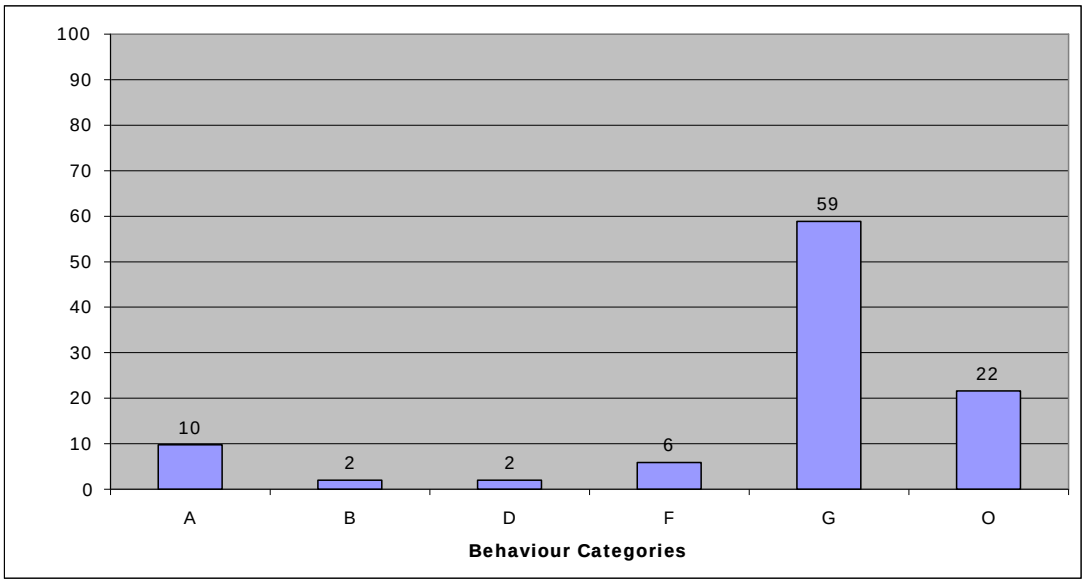
O = Objects: displaying attachment to or relating to inanimate objects and refers to the person interacting with/about or holding the object and talking generally, not reminiscing.

X = X-cretion: any episode relating to a person's need to use the toilet.

Behaviour codes from the three case studies

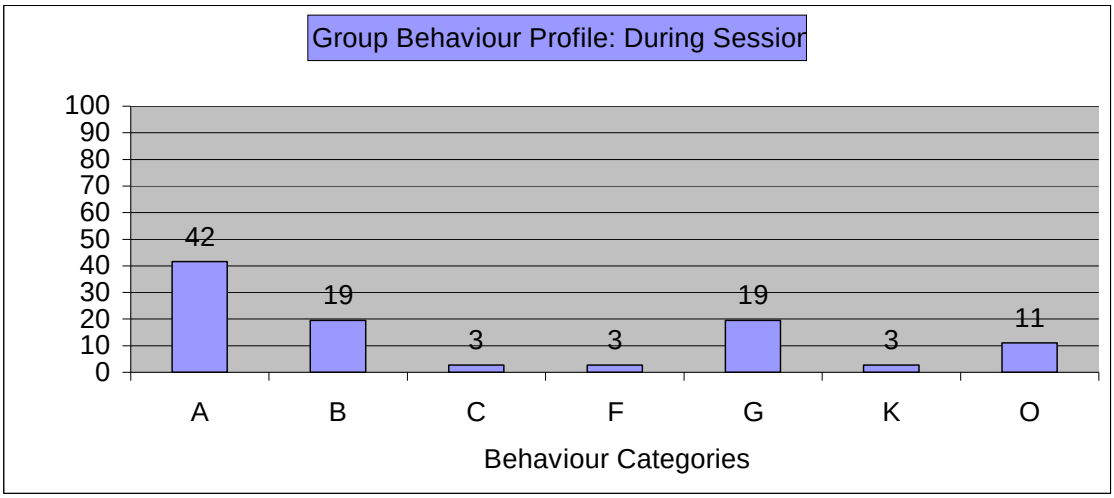
Case Study 1 behaviour codes: During the session, the activities observed were principally to do with reminiscing (nearly 60% of the time), engaging with objects and, to a lesser degree 'articulation' (interacting with others with no accompanying activity).

Fig 4: Behaviours results for case study 1



Case Study 2 behaviour codes:
Behaviour codes during the session include those for 'articulation', 'going back' and 'objects', but also for 'borderline' which indicate the participant was not activity engaged. These participants spend much less time 'going back' and relating to 'objects' than the previous group.

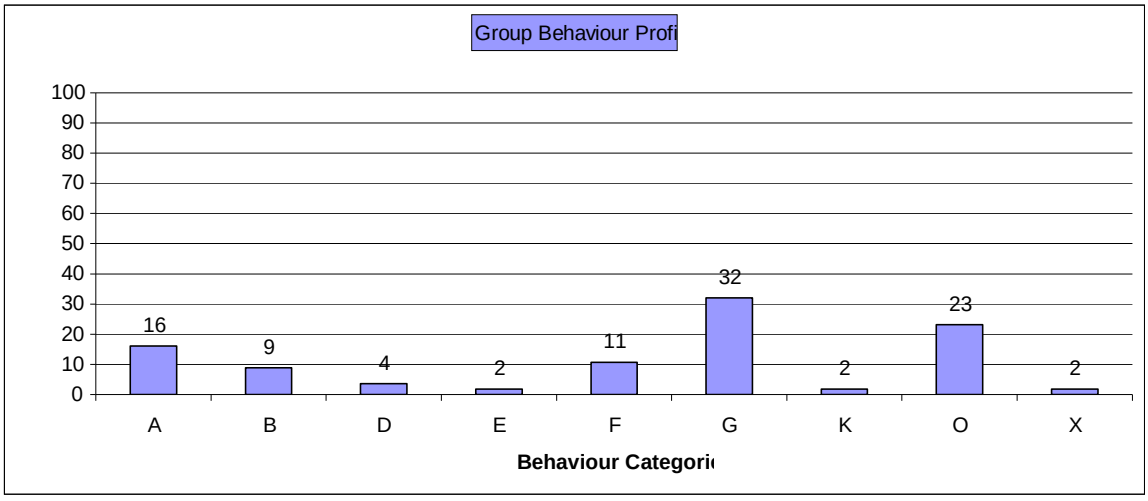
Fig 5: Behaviours results for case study 2



Case Study 3 behaviour codes:

Behaviour codes during the session include those for 'going back', 'objects' and 'articulation'. The 'F' for food relates to tea and biscuits during the session. In terms of the amount of time 'going back' and relating to 'objects' it sits between the previous two sessions.

Fig 6: Behaviour results for case study 3



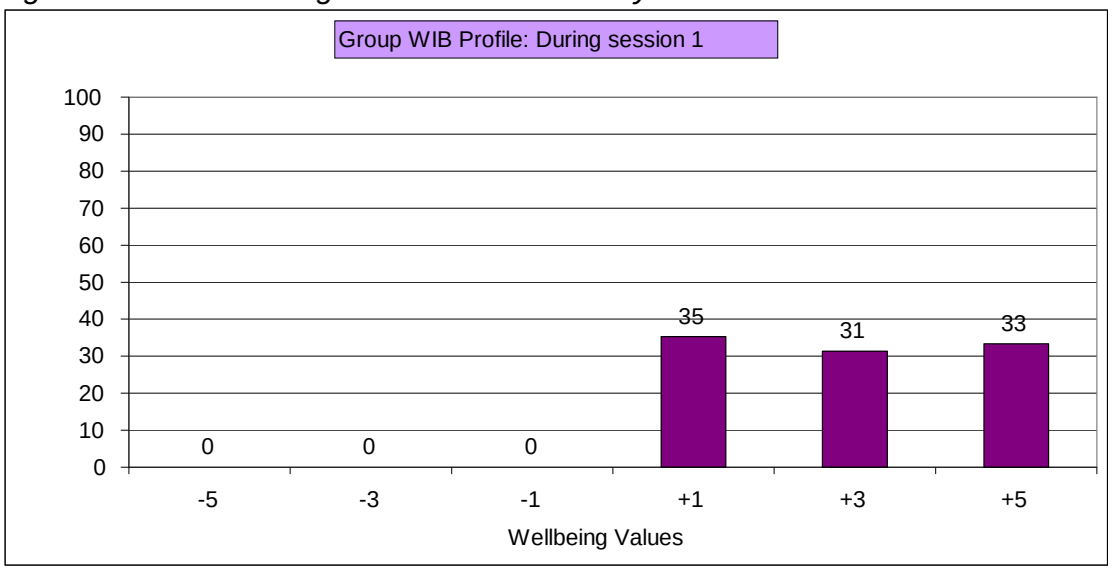
The reasons for the differences between sessions will become clear in the descriptions of the sessions, interviews and recommendations.

Mood and Engagement (ME values)
Well/ill-being scores assess the mood and engagement of those being mapped, they are also known as ME values. These can range between -5 and +5, with +1 being considered a 'neutral' state. In the observations for this evaluation, wellbeing scores between -1 and +5 were observed in the sessions (no scores -3 or -5 were observed). A description of what these scores mean is provided below:

> -1 = the person showing small signs of negative mood or being totally uninvolved and disengaged from their environment, in this case sitting with eyes closed for a whole 5 minute timeframe.
>
> +1 = a neutral mood state with an absence of outward signs of positive or negative mood and/or the person may be alert and focused on their surroundings with brief or intermittent engagement in an object, other person or activity.
>
> +3 = the person appearing content, happy and relaxed with considerable positive mood and/or the person may be concentrating or distractible with considerable engagement in an object, other person or activity.
>
> +5 = the person appearing very happy, cheerful and buoyant with a very high positive mood and/or very absorbed and deeply engrossed or engaged with an object, other person or activity.

Case Study 1 wellbeing results: This session showed unusually high levels of wellbeing. The mapper commented that the highest levels of wellbeing and engagement were observed when the objects triggered past life memories; this was experienced by every participant at several points during the session, when values of wellbeing of +5 were coded.

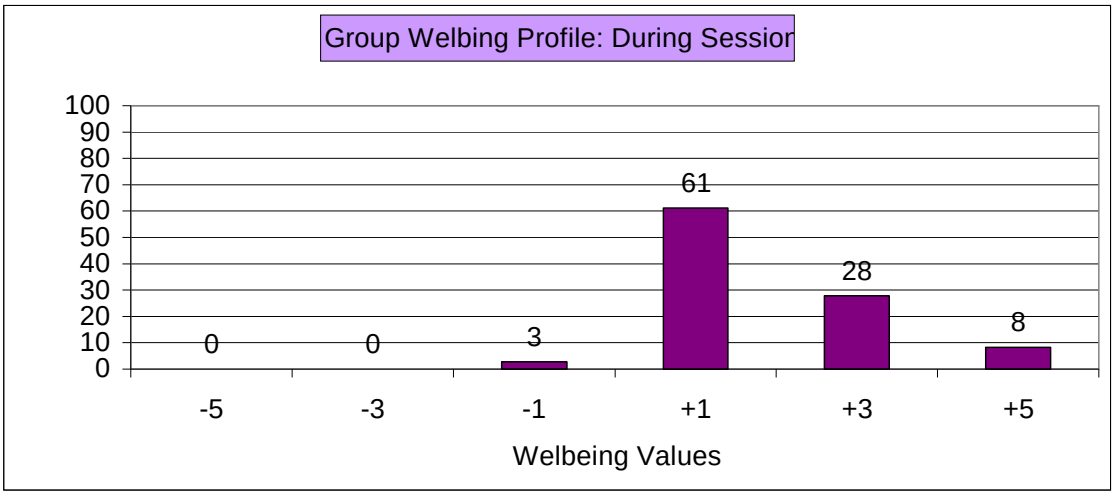
Fig 7: DCM well/ill-being results for Case Study 1



Case Study 2 wellbeing results: A range of ME values were observed. The three people being mapped generally coded with neutral or high levels of wellbeing throughout, however, one participant was disengaged for one 5-minute time frame and coded as -1 (withdrawn and out of contact).

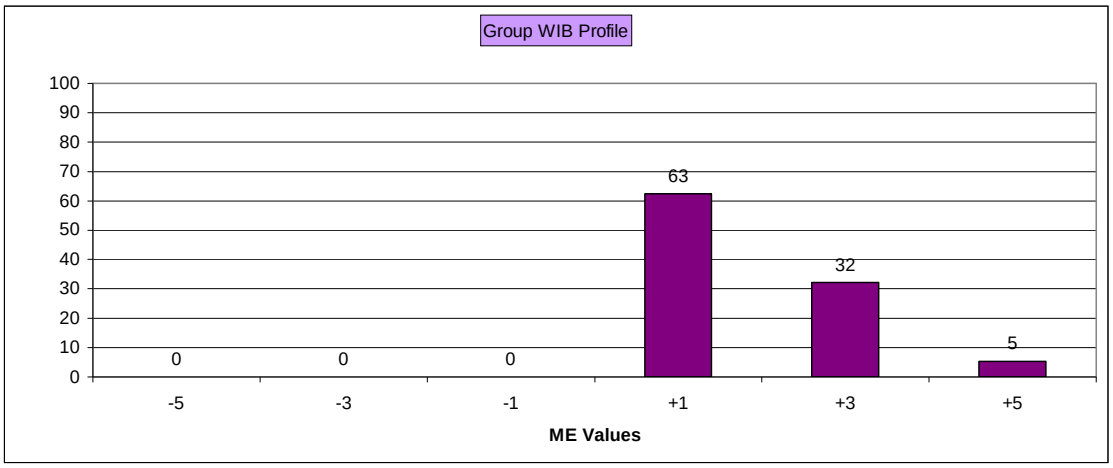
One participant who has a tendency to giggle and repeat comments did so for one time frame without receiving a response from anyone, and appeared anxious until supported by a care worker.

Fig 8: DCM well/ill-being results for Case Study 2



Case Study 3 wellbeing results:
ME values for the group were positive or neutral, no negative values were recorded.

Fig 9: DCM well/ill-being results for Case Study 3

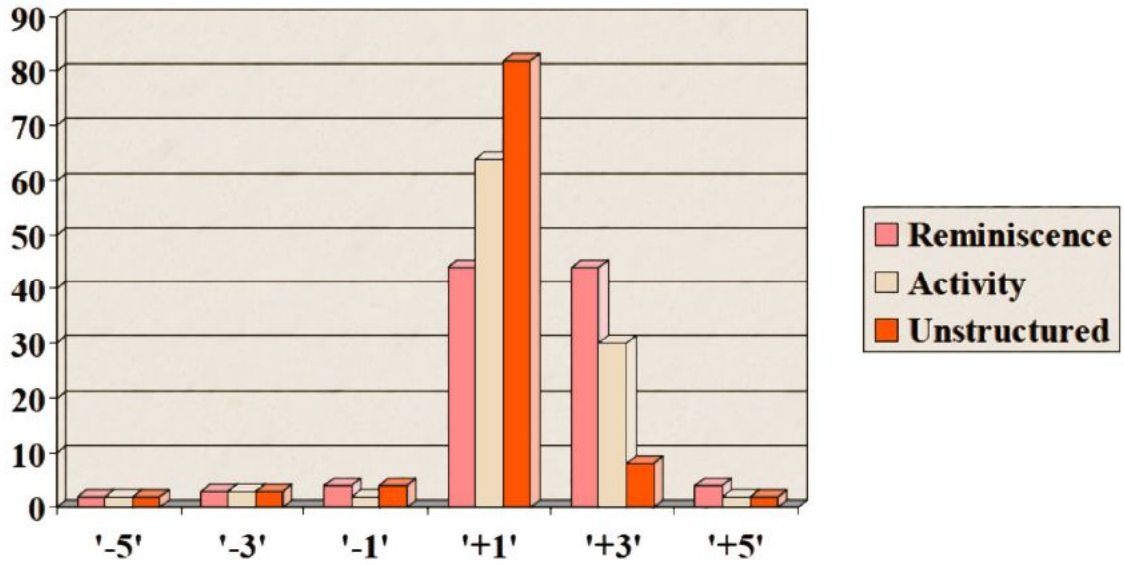


Again, the difference in ME Values between Case Study 1 and the other two will be understood from descriptions of the sessions and interview findings.

6.2 Exploring the Context of the DCM results

The older versions of the DCM guidance gave tables enabling well-being scores to be compared to baseline figures. The latest edition of the manual[29], however, does not provide these tables as (it is explained) they were not based on published data and because scores have been found to vary according to the particular characteristics any group being observed (e.g. levels of dementia). Work is underway to build a database of DCM results in order to provide contextualising information for those involved in research and evaluation. It will be difficult, however, for those readers unfamiliar with this observation tool to make any sense of the results above without some contextualising information. The chart below shows results obtained by Brooker and Duce[30] when comparing wellbeing of care setting residents in three circumstances - in reminiscence therapy, structured goal-directed group activity (e.g. crafts) and in unstructured time. This diagram is included to help contextualise the results for the reader new to DCM with the caveat that, as explained above, many factors will influence scores obtained.

Fig 2: Well-being results obtained by Booker and Duce



The codes in this diagram show that both reminiscence and structure 'activity' result in higher (i.e. more positive) wellbeing scores (ME Scores) than unstructured time. (Scores for unstructured time are principally +1, there are few +3 or +5 scores). Furthermore, reminiscence has the potential for more positive results than 'activity'. Overall, scores of +1, which are considered 'neutral' are the norm.

[29] Brooker D and Surr C (2005) *Dementia Care Mapping: Principles and Practice*, University of Bradford

[30] Brooker, D. and Duce, L. (2000) *Wellbeing and activity in dementia: a comparison of group reminiscence therapy, structured goal-directed group activity and unstructured time*. Ageing & Mental Health, 4 (4): 354-358

What level of evidence do these case studies provide?
As explained above, these case study observations are not intended to provide clinical evidence for the effectiveness of reminiscence sessions in care settings. The study design, the short timeframe during which the DCM mapping was carried out, the small sample numbers and the lack of a control group mean this is not possible, and this was never the intention for this evaluation. The combination of the qualitative observation and the DCM mapping (which was carried out by a very experienced mapper) are intended to generate insight and understanding within the context of this qualitative evaluation. The observations have led to a robust assessment of the quality of provision of the three very different sessions, generated insight into how they may benefit those involved and given some understanding as to what factors affected their success.

6.3 Descriptive / narrative reports of the case studies

Case study 1

The residents and the set-up

Staff and volunteers from the museum shared objects from 1950's they had brought with them. The session was informal and involved eight residents and five museum staff (including volunteers). The residents were grouped around two tables; the two tables looked separately at a selection of objects and articles. There was quite a hubbub of conversation generated by the group activity. The objects were contained within two memory boxes - one of these a plastic storage box and the other the 'dressing table' reminiscence resource; these were swapped around half-way through the session.

A table of four residents and two museum volunteers was observed by both evaluators. The four residents being observed had moderate dementia. Two of them needed higher levels of support and prompting in order to reminisce (with the volunteers handing the objects to the person and asking questions) the other two participants appearing to reminisce more easily and spontaneously

The session and the residents' reactions

The two volunteers at the table being 'mapped' presented to the group a scaled down model of a 1950s style dressing table cabinet with drawers, cupboards and a mirror. Various hats were handed around. The men were particularly interested in these, trying on the trilby and flat cap. One lady picked up a hat and began to talk about her school days to the person next to her. One lady puts on two hats at one time in a comical way. This led to one resident recalling the phrase

'Red hat no drawers'

Other objects such as bow ties and cigarette packets were talked about for some time

by the men to each other. The old theatre glasses caused some group laughter as a participant looked through them the wrong way round, then explained to another how not to use them.

People told anecdotes from their past. One lady talked about how she taught Diana Dors to swim and relayed a story about how she had avoided having to sing a difficult high note when singing solo at a Sunday School performance because she accidentally fell off the stage.

> *'Diana Dors lived with her mother and father near the Swindon Old Town Cinema. We had a wonderful stretch of water right in the country. We had the latest in diving boards. She used to wait there to be photographed. I pushed her in'*

The objects were handed around or placed on the table at a very relaxed pace, giving plenty of time for everyone to see and touch. The texture of some objects, particularly the lace handkerchiefs and kid gloves, was felt or stroked, which helped to prompt memories, but also some discussion about the textures themselves.

Residents reached out for and engaged with objects of their own accord, one lady had a really good go at opening a lipstick that was stuck; she really persisted with it. The gentleman sitting closest to the cabinet began to open cupboard doors to see what else was inside, which sparked a conversation among all four about the game 'shove ha'penny'. An examination of the high heeled shoes, nylons, jewellery and make-up inspired reminiscence about going out and dancing, with lots of laughter and smiles from all four participants. One lady teased one of the men about wearing eye-shadow as it was handed round.

> *'I went dancing before I was twenty. That's where you met the fellas!'*

A little later on, one gentleman was engrossed in reading an old newspaper with a big smile and the two ladies were looking through an old recipe book together sharing memories. A gentleman studied with great absorption a pair of fine leather shoes.

A volunteer skilfully facilitated the quieter of the two gentlemen into a sustained conversation about his RAF days (coded as +5 on the DCM Mood and Engagement scale). Staff at the care setting had explained that many of this person's expressed memories from this time are traumatic, but the quiet one-to-one interaction with the volunteer using objects from the time seemed to support his wellbeing to a high level on this occasion. Whilst it is speculation, it is possible that his positive responses may have been facilitated through the use of objects leading to the recall of positive (rather than solely traumatic) memories.

At times, the objects were just held, sometimes manipulated or shown to others and talked about in general terms. Residents investigated the objects they weren't familiar with or couldn't get to 'work'. Several times residents demonstrated how to use the objects or 'mimed' actions; their animated behaviour being in contrast to a more passive state observed before the session. It seemed important that the participants were able to

do this, as the mimicking of an object's use seemed to support the accessing of memories, perhaps through the body 'doing'.

Conversations were rarely held across the whole group. More commonly, residents would chat with their nearest neighbour, either another resident or a museum volunteer/staff member.

As the evaluators were leaving, the quieter lady from the observed group joined them, continuing her conversations and laughing with great enjoyment about her dancing days; her wellbeing and confidence apparently improved, throughout the course of the session.

The Care Setting Staff

The member of staff at the Care Setting who organised the session felt it went very well. The activity was able to bring back some lovely memories for the residents and was entertaining, as evidenced by the laughter. Residents with dementia were able to join in. The session was seen as having lifted the mood of the residents, with some of them commenting positively about it in the afternoon (the session was in the morning). The staff member felt that the hats worked very well, as did the books and magazines, because they evoked emotional responses. The specially shaped dressing table was also a good idea.

This member of staff had carried out reminiscence activity before using newspapers, but it hadn't appeared to work so well; he speculated that this was possibly because of a lack of knowledge or first-hand experience about the objects (it may also be due to not having such high staff ratios). The sessions at the care setting (there were two sessions altogether) had consequently showed him the possibilities of reminiscence and resulted in him feeling more positive about it. He had not previously had training in reminiscence and expressed an interest in this.

This member of care staff was asked about the value of volunteers delivering this activity, as opposed to it being done in-house. He felt that the two things were different, as volunteers are able to have a different relationship to residents 'more like friendship'; additionally, when people come in to the home there is a sense of occasion and 'razzmatazz'. It lifted the atmosphere.

Museum staff and volunteers

Including the evaluators, there were fifteen people present at the session. The group was based in the sitting room of one of the residential flats at the care settings. A bigger room had been planned for the session but was unavailable at the last moment. The noise level was at times quite high, which could make it hard to hear, particularly as one volunteer did not have sharp hearing and because one of the residents spoke quietly. Lack of space also made it difficult to spread out the equipment.

This session had an unusually high ratio of staff to residents. Museum staff and volunteers felt this contributed to the session's perceived success; a past session had involved a larger number of residents and was not felt to have worked so well.

> *I don't think you can communicate properly with more than 2 people at a time.* [Museum staff / volunteer]

> *I think it's quite important, because you not taking a class, you're having a conversation* [Museum staff / volunteer]

Some objects worked particularly well in the session (for example the hats), the museum volunteers noted, however, that responses to objects varied from session to session. A member of staff commented that, with some objects, a level of knowledge was required to get a conversation started, for example she had difficulty with a tablecloth embroidered with the signatures of old film stars whom she did not know. This staff member suggested that the memory box contain further information about this and other objects as, at present, its potential for stimulating conversation was less than it might be. This issue of a lack of knowledge of objects in memory boxes was also raised by the member of care setting staff interviewed.

> *… some of the things I haven't got enough experience yet to know how to put them over.* [Museum staff / volunteer]

Reflections from the evaluators and development points

Lack of space meant that there was difficulty in seating everyone and, once in, it was impossible to move around the group or easily leave the room. Whilst the noise level was at times quite high, this was also a strength of the session as there was a feeling of high energy, hustle and bustle which was quite exciting. The television in the room was left on which added, perhaps, unnecessarily to the noise.

The seating arrangement, in small groups around tables appeared to work well and gave the opportunity for group discussion with the whole table and one-to-one discussions with neighbours; in the session the conversation ebbed and flowed in a natural way between the whole table and individuals. The relaxed pace of the session was a success factor in its delivery.

The number of staff / volunteers enabled 'quiet one-to-one support of participants' in some instances - this would have been difficult without these staff ratios and a factor in the success of the session.

The lack of space on the day meant it was not possible for most people to have access to the 'dressing table' to get things out for themselves. The volunteers took objects out and laid them out, which meant that residents lost out on the 'discovery' element of the dressing table which is a very tactile object. This was beyond the control of those doing

the session due to the last minute room change, but is a point for consideration for the future. The cups from the cup of tea, which preceded the session, were left on the table which felt confusing when the objects first came out.

There were several residents in the room who did not join the session. All had been invited and some declined to join but nevertheless might have been given opportunities to join in at a later point.

Objects with textures worked well in the session and the sensory value of objects could be considered when planning boxes as they may help promote memories (textures, shiny colours, sounds, smells). The same observation was noted of those objects that encouraged movement of some sort, for example, mimicking an object's use.

Case study 2

The residents and the set-up

The session began just after 10.30 a.m. Residents had been invited to the lounge during the morning. Museum staff and volunteers (one paid member of staff and two volunteers) arrived a little late due to poor driving conditions after a long journey and started the session immediately. The room had been set up with a table from the dining room. Museum staff asked care staff whether it was better to invite people to sit at the table or stay in their chairs, and care staff said it would be better for people to stay in their chairs. There were ten residents in the room, a small number of these formed a 'sub group' in a bay window, the rest were seated around the edge of the room. There were two members of care staff present throughout the session, they had also been present when residents were waiting for the session to start. With the three museum staff and two evaluators the room felt full.

The home manager came in and introduced the residents to the museum staff. The dressing table was put on the table and objects subsequently handed round to residents by the museum staff. The objects are consistent with the 'dressing table' theme; hats, grooming objects such as combs and brushes for both men and women, stockings, a lavender bag, ties and belts.

The session and the residents' reactions

The objects that seemed to work very well were the hats. When several hats were put on a tray table in reach of the residents, one gentleman picked up a colourful lady's hat and put it on to the obvious amusement of the ladies next to him; there was sustained laughter. Later he swapped this hat for a trilby and a lady sitting near him laughed and said

'You look older in that…you look like your father!'

He took this comment in good part; in fact they seem to enjoy the interaction.

The other ladies in this ‘sub group’ sitting in the bay window also tried on the hats. The hats were distributed to other residents but they didn’t try them on. One was beaded in an ornate way and one lady commented on the amount of work that had gone into making it.

One lady talked at some length about the fact that she played the piano by ear and was encouraged by her mother who had more than one piano in the house. She also taught her husband to play

> *“He asked me what to do, then he became quite good!’*

A cummerbund and several ties including a bow tie were handed to the gentlemen sitting on one side of the room. The member of museum staff who gave him the things then took other things out of the box to give to someone else, so the gentleman with the ties was left holding them with no one to talk to about the objects.

Another museum volunteer sat next to two ladies on the other side of the room and engaged one lady in conversation, occasionally leaning round to talk to the other lady. However, it was hard to maintain contact with both ladies, because of the arrangement of chairs and the lady at the far end eventually left the room, having said she wanted to go.

Two ladies in the ‘bay window sub-group’ talked about dancing and clothes. One lady, having talked about her many dresses and said

> *‘My husband was in the army and I didn’t see him for two years. When he came back I wore them all.’*

One lady in the group had a piercing laugh, which was almost constant and did not appear to be a laugh of pleasure. It meant that the noise level was high and it was hard to have intimate conversations.

The session seemed to be most successful for the people in the sub-group sitting in the bay window of the room. They were seated centrally in the room and the energy of the group was concentrated in that area. The attention focused around that group of people pulling the museum staff’s attention as well as that of other residents.

The set-up did create difficulties in engaging residents. The volunteers had to take objects to several people and then it was difficult to focus in on any one individual in order to encourage conversation. Residents were consequently sometimes left with objects and no one to talk about them with. In these cases, there was also little opportunities for interaction between the residents or the possibility of residents taking

initiative and spontaneously picking up or selecting objects (off a table for instance).

In some cases objects were shown to residents and not handed to them. It may be that this was done in order to address as many people in the room as possible by showing the objects to the whole group. This resulted, however, in residents not having the opportunity to have a sensory experience. Quite a directive approach in questioning was used in this instance, for example, 'Does anyone remember these?' resulting in few responses from residents.

The Care Setting Staff

Care setting staff involved themselves in the session; two care workers were present for the whole of the session and been present beforehand, supporting residents to get settled in the room and chatting to them while they waited for the session to start.

Care staff at the time felt that the session has been particularly helpful for some residents (but not all) in giving them opportunities to interact with one another, staff and museum volunteers and staff.

The museums volunteers and staff

The session had been different to a previous one at the same care setting when there had been fewer residents (five as opposed to ten) and it had been possible to put a small table in front of them. Although there had been dialogue with the care setting prior to the session, the main contact (who had also been on training) had not been able to be present on the day which may have contributed to the problem. At this session there were more residents and they were sitting in big, heavy chairs that the museum staff felt would have been difficult to arrange around the table. Road conditions also meant that when museum staff arrived there was not much opportunity to consider this issue. On the whole, they felt that, although some residents did benefit, it was not as successful as the previous session.

The number of residents and the layout caused difficulties, one of the team mentioned having to make a conscious decision to focus on a particular participant who was hard of hearing, knowing others may not get so much attention. Another wondered if it were possible in future to find out about residents interests from the care home in order to provide relevant objects. One of the staff present mentioned that while normally talkative, she occasionally found it difficult to keep conversation going when getting a minimal response; as in the previous case study, this volunteer also asked for further information about the objects in order to assist her when stimulating conversation.

Reflections from the evaluators and development points

The session was run at a relaxed pace and participants engaged with and manipulated some of the objects, particularly the hats. There was quiet one-to-one support of the residents, all of whom at various times experienced considerable levels of wellbeing and

engagement. Not all objects triggered reminiscence and a wider range of objects, for example relating to the local farming scene, may have been useful.

The numbers of people in the room and their positioning in chairs around the perimeter of the room meant that the effectiveness of this session in supporting people to reminisce was impeded. Residents could not choose objects themselves and because they had relatively few opportunities to handle the objects, the full potential of the objects to release memories was often unrealised.

Case Study 3

The participants and the set-up
The session began as people returned from lunch to the activities area of the centre. The room had been arranged with chairs grouped around a single table, excess furniture having been removed from the room.

The session facilitator put on some music (Fred Astaire) in the background as people came in. There were four service users in the session, all of whom have dementia which affects them in a variety of ways; care staff in the DCM pre-meeting had commented on worries about one lady's of engagement while attending the day centre due to her verbal communication difficulties. It was felt that sometimes her tendency to repeat phrases and other efforts to communicate 'irritated' centre attendees at times. People around her were not sure how best to engage her in activities.

Two of the care staff team were also present at the session.

The session and the participants' reactions
The session started informally with a hot drink and biscuits. There was some interaction across the whole group at this informal stage. The only gentleman in the group related a story of winning a medal for athletics in Bengal when he was doing national service in the Royal Air Force. The facilitator retold this story to the others in the group as they had not heard and they responded. One lady said, as she clapped her hands 'That's wonderful', another said 'He got a medal!'

The facilitator introduced the topic of biscuits. The gentleman talked about large biscuits he had brought from the co-op that came in a tube. She then outlined what the session was about. She explained that she had brought some objects from the museum 'just to get us talking' and that there was no obligation for anyone to share memories and that it wasn't a quiz.

One of the ladies talked about how she had been ill and had problems with her memory. Her expression was one of loss but also tenacity in the face of her difficulty.

A trug-style basket covered with a colourful crocheted blanket was offered around and

each person was invited to put his or her hand in and draw out a ‘mystery’ object. The facilitator guided the conversation, inviting each person to identify and comment on the object they had chosen.

The gentleman identified a darning mushroom, a discussion about mending took place and he demonstrated how a darning mend is made by interlacing his fingers; he later talked about the fact that he darned socks when he was in the air force. This gentleman contributed a number of memories throughout the session, recalling, for example, an anecdote about how he could get into the Eisteddfod for free because his friend’s house backed on to the show ground. They would jump out of the window and lift the flap at the back of the tent and get in for nothing.

The lady who had earlier acknowledged her memory problems told the group that she was from a family of thirteen children. She returned to her family later in the session recounting, for example, a detailed memory of her father, ‘a very hard worker’ who had a job delivering bread using a horse and cart, out on the road at six o’clock every morning. One day there was a thunderstorm, the horse bolted and her father ended up in hospital with a broken leg, but was back at work six weeks later. She remembered how her father and his horse were ‘inseparable’. Her father’s philosophy of life was

> *‘You’ve been given life, so get on and use your life.’*

At another point, when looking at some buttons, she was asked if she had ever made her own clothes and said

> ‘*I can’t always see myself in my family, getting on with my life. Part of me has been getting lost’.*

The participant with communication difficulties watched others select objects with a smile, then laughed when it was her turn and pulled out an old marmalade pot. She read the label and then made play with the phrase ‘Chivers marmalade’ repeating it many times in a rhythmic way whilst tapping her hands in her lap, which seemed to give her pleasure. She clearly engaged with the object and was coded in the DCM and O+1.

The next object resembled a plunger. It took time to identify this object and the facilitator revealed that it was a posser, used to wash clothes. This prompted the gentleman to reflect that his wife had a washing machine, implying that she had one before other people. He appeared proud of this fact.

> *‘My wife wanted one. I worked for British Rail and I got it.’*

The participant with communication problems was asked by the facilitator where one might do washing in one’s home and replied ‘at home’. This was one of the few times she directly responded to a question, however, she was attentive throughout and enjoyed using language to create rhythmic phrases. Later in the session she was handed a bar of Lux Toilet Soap and repeated the phrase “Lux toilet soap, Lux toilet

soap" with apparent pleasure, coded with a ME value of +3. Whilst others were talking about the soap, however, she said under her breath 'What are they talking about, silly buggers'. At one point in the session, another participant felt her conversation was being interrupted by this lady making a noise slapping her own leg and said; "do you mind dear? I'm talking".

As the session progressed sustained conversation ensued about the possible purpose of some of the objects, with the facilitator asking questions of each participant. Sometimes the conversation was about the objects, at other times about personal life reminiscences.

The lady who had earlier acknowledged her own memory problems and the gentleman showed an active interest in what others had drawn out of the basket, leaning forward and commenting. At one point the lady encouraged the participant with communication difficulties 'Put your hand in…choose something'. The highest levels of wellbeing and engagement were observed when the objects triggered past life memories. These two participants spent the remainder of the group activity highly engaged in each other's conversation about their shared memories; coded as G+3/G+5.

The final participant who was sitting more closely to the table quietly listened and intermittently observed what was going on. She briefly engaged by picking up objects left on the table then putting them down. She appeared neutral in mood, coded as ME value +1 throughout the whole group activity. She also seemed distracted at times, looking at her watch. At one point, this participant had been asked about jams and marmalades and had replied, 'What am I supposed to tell you now'. At times she seemed uncomfortable when asked direct questions and replied that she didn't remember on a number of occasions. During the discussion about shopping, however, she mentioned a supermarket she had used, the Acme, and the benefit it offered.

'you didn't have to walk to so many places'

She also talked about having clothes made for her.

The facilitator ended the session formally by thanking everyone. The conversations continued informally as the participants got ready to leave for home.

Reflections from the museum facilitator

The facilitator found the session was hard work as she felt that two of the participations were not necessarily getting much from it. In the groups she normally runs, not everyone has dementia, which might have contributed to the perceived difficulty. While the facilitator knows the centre, she did not know the participants and it is felt it harder to do a session 'cold'. She also felt that the way the objects were shared may have put one participant under pressure as she was expected to comment in specific ways. If she were to work with this group in future, she would consider a less structured approach

and allow more opportunities for one-to-one work. She felt that using objects can be helpful to some people who don't want to say anything by giving them something to focus on.

The facilitator felt that, key to the success of these sessions, is relationship between the museum and care settings. This is because care staff have knowledge of the participants, and museum staff of the objects. She felt that ideally sessions should be jointly planned and expertise shared and that a series of six sessions in as many weeks works better than one-off sessions.

The facilitator felt that museums, especially social history museums, are well placed to do this work. She gets satisfaction from doing reminiscence work as it can feel isolated in a museum and it is rewarding to listen to people's anecdotes and the stories prompted by the objects.

The care setting this session was held at has done a lot of reminiscence work, but in the facilitator's experience, care settings with little experience can misunderstand the purpose of reminiscence. It can be used to 'fill time' and groups can end up being too large.

Reflections from care staff

A member of the care staff shared her reflections of the session. She thought the session was excellent and worked particularly well for two of the participants. She liked the use of the basket to reveal the objects one at a time and thought the group was the right size. She had noted that in bigger groups, especially where there are people without dementia present, those with dementia can retreat into themselves.

She was surprised at how little one participant contributed (the lady who seemed averse to questioning) and felt this offered some learning for different approaches. She observed that both this participant and the participant with communication issues seemed a bit bored at times. It was positive, however, that the latter's hand tapping and verbal repetition were quieter and less of a disturbance than usual.

On reflection, there could have been further discussions with the museum facilitator prior to the session. Care staff has been asked to fulfil a 'supportive role' but more detailed instructions would have been useful, for example, whether it was acceptable to individually talk to and support residents. This member of the care team and others at the centre have been trained in reminiscence techniques and use them as part of their work. She was positive about having external facilitators visit the centre, as she felt it enabled care staff to learn about other approaches and because they are fresh faces for residents. She was positive about continuing to work with local museums to deliver reminiscence.

In conclusion she commented on the improvements in wellbeing experienced by those in the session, that 'for those moments, those people are sharing of themselves and

being listened to, which can only be wonderful and beneficial'

Reflections from the evaluators and development points

The general atmosphere that the facilitator created during the session was warm. The group starting off with the popular topic of favourite biscuits and the enjoyment of eating and drinking was experienced by all present. The pace of the session was relaxed and participants clearly felt able to disclose personal memories and some difficult feelings. The music playing as people entered the room, helped generate an upbeat atmosphere.

Three participants experienced some considerable levels of wellbeing and engagement. The session was most obviously successful for two residents who both accessed memories and took pleasure in the social nature of the activity. They paid attention to one another's' stories and used non-verbal cues as they listened to each other. Even though the participant with communication issues did not join in the conversation, she responded in unconventional ways, appearing engaged.

The facilitator determined the flow of activity during the session and this might have inhibited the care staff present from individually engaging with and supporting those participants with greater need. Greater clarity about their role might have enabled them to engage one-to-one with those participants who were less able to freely participate in group conversation.

It may also have been helpful to lay the objects out on the table to allow the participants to handle them independently and at their own pace, particularly as one individual had difficulty with direct questioning and another poor verbal skills. In fact, items that had been removed from the basket and laid on the table were later picked up and manipulated by these individuals. A larger range of objects in future may invite more opportunities for sustained engagement and recall of personal memories, particularly objects with high sensory value (sounds, tastes, smells and textures).

6.4 Conclusions from the case studies

The first case study showed very high levels of well-being and positive effects on residents were observed; it demonstrates the potential of museum-led reminiscence sessions in care settings. The session encouraged residents to interact, not only with museum staff, but with each other. It evoked laughter and pleasure. The outcomes from the second case study were more mixed, largely because the layout meant some residents were not fully engaged. Levels of well-being were, however, generally good and high in those instances where residents were activity involved in reminiscence. The third session had positive outcomes for three of the four participants (with neutral outcomes for the fourth). Again, the highest wellbeing scores were noted when reminiscence was actively taking place.

Numerous factors affect the delivery and success these types of sessions, and the best

laid plans can be thrown by circumstances on the day (as illustrated by two of these case studies). Due to the number of variables involved it would not be sensible to suggest that three case studies can provide hard-and-fast rules for delivering reminiscence, however, the three very different sessions and the mixed success of them, do allow some tentative suggestions for future practice.

What the sessions seem to suggest is that interaction is improved when sitting in small groups rather than scattered around the room, particularly as these sessions aim to encourage interaction between residents as well as with staff. This is not always easy to achieve if sessions are held in a space where residents are used to sitting in a particular place or chair. Participants with dementia need a high ratio of staff and some may require individualised support. Whilst it may seem contradictory to suggest both a group setting and individual support, in the Case Study 1 this was achieved through the focus switching between whole group interaction when the table was addressed by the facilitator, and periods that enabled one-to-one interaction and support.

Observations from these case studies suggest that objects should be laid out so that participants can take the initiative and pick up what attracts them, particularly if they are not able to easily communicate or may find it uncomfortable being asked to speak. A wide choice of objects that appeal to people from a range of backgrounds is suggested, especially those that are multi-sensory (colours, textures, sounds, smells). Objects that provoked actions (e.g. trying on hats) or a 'mimicking' response (i.e. the mimicking how the object was used) also appeared to engage residents well. The use of music at the start of Case Study 3 created a relaxed atmosphere. Information about objects was found to be needed in a number of cases, as without this background knowledge, it can be hard for staff to stimulate conversation.

Many of the factors needed to deliver a successful session are in the hands of the care setting staff, for example organising the appropriate group size and composition (e.g. level of need) for the available personnel. It is clear that care setting staff did their best to assist, including being present at the sessions. Care staff do, however, need clear instructions on what to do, for example whether they can engage residents one-to-one. There were some practical issues such as the difficulty of background noise, over-crowing and room set-up, even though museum staff had been in prior contact. While it would seem that these issues are common and sometimes unavoidable, it may help where there is adequate time before a session to look for remedies although it is appreciated it must be difficult as museum staff also need to take heed of care staff advice and of their established ways of working.

For sessions to be a success, the care setting and museum need to work in partnership; this will be helped where care staff are trained in or have experience in reminiscence and where several sessions (rather than one stand-alone session) are run. Involving staff in the sessions will also raise awareness and understanding.

Reminiscence work can be emotionally draining as well as very rewarding; volunteers and staff do need support and training. A probationary period may also be helpful for all

parties as this work is not for everyone. Opportunities for museum volunteers and staff to share experiences with one another were identified as important to the development of the work. It was felt that these help improve confidence and share good practice.

7. Interview Findings

The following findings are taken from interviews with museum staff and volunteers, care staff and other professionals (mental health professionals, reminiscence trainer).

7.1 The involvement of museums in reminiscence activity

Museum staff and volunteers felt that the main driver for delivering reminiscence activity was that it is part of a museum's role to take collections out into the community.

> *Local outreach and engagement with the community is vital for museums* [Museum staff/volunteer]
>
> *It reaches a part of the community who may not be able to physically access the museum and provides a useful stimulus for people who participate. [Museum staff/volunteer]*
>
> *Outreach is a very strong part of our provision anyway and you should be offering outreach to anyone who wants it, no matter what their disability. [Museum staff/volunteer]*

Reminiscence is seen as being able to raise the profile of the museum in the community and satisfy funders and other stakeholders.

> *I think that it could, from a museum perspective could tick a lot of boxes, reaching hard to reach audiences, getting your stuff out into the community, and it's linking to the communities. [*Museum staff/volunteer]
>
> *It makes you more visible. A related but different point is, why are you collecting stuff? …In a museum like this … we're collecting much more everyday stuff that relates to everyday people's way of life and so the whole point of it is to share it. [*Museum staff/volunteer]

One museum felt that part of its role was to enable people to connect with their own memories.

> *Museums should be selling themselves as centres for reminiscence. People should be able to come in and refresh memories 'look at this, I remember that'. [*Museum staff/volunteer]

Museums are also seen as being ideally placed to provide the reminiscence through the staff's knowledge of history and access to resources. The staff and volunteers are considered well-placed to deliver reminiscence because of their interest in history and often, people's stories.

> *You get the sense that some of the volunteers have chosen to be (involved) because they are interested in history. It's a useful quality to have, they are*

enthusiastic and it helps stir memories. [Health professional]

*The volunteers have amazing background knowledge as well. [*Museum staff/volunteer]

*I'm nosy; I'm interested in other people's lives and I think you get to a certain age where the past is interesting isn't it. [*Museum staff/volunteer]

For most museum staff and volunteers, delivering reminiscence was a rewarding experience.

*The information we found out was really interesting, when people start telling you their stories their eyes light up, it's very rewarding, it's very lovely [*Museum staff/volunteer]

*…knowing for that for most of those people they are going back to a time that they felt valued and important. They are getting some attention and they can tell you about their grandchildren and you can see that it makes a difference for that short amount of time [*Museum staff/volunteer]

*I've found it very rewarding. It makes the brain work on so many different levels. Being involved with different people from so many walks of life. [*Museum staff/volunteer]

*Seeing people's eyes light up and having that contact, I think it really does, for some of them, provide an interesting part of the day, so I do think it's worth doing definitely. [*Museum staff/volunteer]

*For me that's where I get the most out of it; to think that I've done something for somebody or helped somebody [*Museum staff/volunteer]

Some were doing reminiscence having had experience of a family member who had been in a care setting or who had dementia, and this gave the motivation.

There were times, however, when delivering reminiscence could be difficult, even for those to whom it came naturally. Not all memories are good ones, and people do get upset. For those not used to the care environment, particularly where there are residents with higher levels of need or more advanced dementia, it can be upsetting at first.

*Yeah it can be, and I am sometimes quite depressed. … that day's training was very sensitive to that sort of thing, so that helped, but nothing really prepares you for going in. [*Museum staff/volunteer]

*When he heard residents shouting he got really worried. [*Museum staff/volunteer]

For these reasons it was the case that staff and volunteers found that informal debriefing (discussing the session afterwards) could be helpful; it was the view of one professional

that it might be worth ensuring that the need for debriefing was acknowledged.

> *I think they have got to be told at the outset that they must discuss things like that and not go home and be upset….maybe set in a compulsory debriefing time, and it could be positive debriefing time as well, because sometimes you come out and you are on a high. [Health professional]*

Related to this is the importance of recruiting the right people to do this type of volunteering.

> *I think that it is recruiting the right people for the situation … it is not for everyone. [*Museum staff/volunteer]

> *The volunteers I take in are prepared for it, they have either had Alzheimer's or other elderly cases to look after.* [Museum staff/volunteer]

The lead on a reminiscence project that involves more than one person has the responsibility of coordinating and recruiting volunteers, and this can require skill, particularly where a volunteer is inexperienced:

> *They would have to go in with an experienced person leading them, just so they can see what it is like and you would talk to them afterwards* [Museum staff/volunteer]

Although not a specific area covered by this evaluation, issues around protecting vulnerable adults were seldom raised and in a couple of instances there appeared a lack of clarity about this.

While museum staff and volunteers were normally positive about doing reminiscence sessions, there were occasionally some conflicting feelings about their role. This may be a particular problem where individuals are used to oral history, which has a very clear and identifiable purpose and end product. The role of the museum volunteer or staff and that of the resident when doing reminiscence is more ambiguous, as the situation more closely resembles 'natural' conversation.

> *What were we there for, for our benefit or theirs, or both? How did they feel about us turning up?* [Museum staff/volunteer]

> *I think I'm too old. I'm too near their age; in fact I'm older than some of the people in there. They've got plenty of people my age sitting around them.* [Museum staff/volunteer]

In fact, a number of respondents felt that memories from reminiscence should be recorded in some way (as in oral history). Perhaps this response is not surprising given that a key role of a museum is to collect for posterity. It was not, however, only a sense that the memories were being 'wasted', but also (rather touchingly) that it was a mark of respect to treat the information that is being imparted as valuable and thus keep it in some way.

We need to give some recognition to people who participated about their memories. [Museum staff/volunteer]

This raises interesting questions when one considers that, when doing life story work, information is recorded through the creation of life story books or boards; the difference between this and oral history is that the primary purpose of life story work is not to collect for posterity but to provide person-centred care or as a form of therapy.

Museum staff can also sometimes feel under-confident about their own skills, this was something noted in the case-study observation, where volunteers occasionally undervalued the sometimes very skilful approaches they had taken.

The loans box idea I think is quite a good idea as obviously the care home staff are far more, you know, qualified and know how to use the objects better. I often feel a bit sort of amateurish when I go in, but I mean, we are perfectly happy to go in and do it as well. [Museum staff/volunteer]

Reminiscence work was not generally felt to have impacted on museums' own practice in a tangible manner, although one museum pointed to a change in its collecting policy as it was now collecting some objects specifically for reminiscence (and therefore had the freedom to collect objects that did not necessarily have a specific local connection). Reminiscence work can, in some instances also bring less tangible outcomes to museums through increased understanding of different audiences.

For me it has been real eye-opener, and a really useful education as well… but it's made me more aware of the audiences who come to the museum and the physical difficulties they might face. [Museum staff/volunteer*]*

7.2 Working with care settings

Whilst many care settings do a range of reminiscence activities themselves, care professionals did see a role for museums. While it is important to embed reminiscence within everyday practice in care settings, the value that volunteers have, coming in as fresh faces, is rated as important by care staff and museum staff and volunteers.

There is absolutely no doubt that the volunteers should be there; they are dedicated. [Care staff]

Volunteers come with fresh eyes; they are unbiased about residents [Care staff]

Volunteers come in as fresh faces; this can be a benefit as they provide something different for residents, some of whom may not receive visitors. But it is important for museums to discuss residents' needs with care staff before visiting so as to be aware of any issues [Care staff]

Care staff are also hard pressed to offer concentrated time with residents and museums staff and volunteers can provide extra quality time. [Health professional]

In fact, in some instances, care setting staff may feel under-confident about working with historical objects, perceiving museum staff as having better background knowledge. Museums were also seen as a potential source of resources, one museum for example receives frequent calls requesting advice on putting together memory boxes. Museums can also potentially encourage reminiscence and help inform staff.

> *They can show care staff, particularly newer and younger care staff how to use prompts such as objects, photos and things, they can play a part in that. And can also play a part if care homes want to set up their own reminiscence boxes or reminiscence areas*. [Health professional]

> *If the care staff are familiar with what is available and what use could be made of it, it wouldn't be so necessary for staff to come out from museum … but at the moment we would still need staff to come out to demonstrate to our staff what to do, after that we could make more use of just borrowing just boxes* [Care staff]

> *Museums can help with sources for how to get access to materials,* [Care staff]

> *Staff should be present in case residents get upset but also so they can learn.* [Care staff]

> *With the dressing table, in fact it encouraged me to buy things to add to our reminiscence (collections)* [Care staff]

Evidence from the observation studies indicate that reminiscence can also be a positive experience for residents, bringing them into contact with members of the community, promoting social interaction and providing an enjoyable experience. Care settings are positive about museum reminiscence sessions.

> *They did several sessions, and had a tea party. People who were in the group really enjoyed it and really benefited from it. It was someone else for them to talk to about different things.* [Care staff]

For sessions to go smoothly a good understanding between the care setting and museum is needed. A member of care setting staff should be present and the number of residents appropriate for the number of museum staff / volunteers. Care setting staff can also provide information about the level of ability of the residents and of any topics to avoid.

> *It depends on what the manager wants. It is important to have dialogue with the manager beforehand as there may be things to avoid e.g. something upsetting.* [*Museum staff/volunteer]*

In many cases excellent provision was made by care settings and in some cases care staff assisted with the activity. In a few instances, even when discussions have taken place prior to a session, problems arose.

> *We had got about thirty people in the room there and poor X was trying to deal with*

all the people that we weren't talking to around the tables. [*Museum staff/volunteer]*

Some of these issues may be unavoidable but it is probable that some are due to a lack of understanding of what reminiscence entails.

> *It can be seen as an activity, a bit of a show. It is difficult to do on your own with people lined up in armchairs. You need detailed conversations with activities coordinators and members of staff establishing what you want for the session. [*Museum staff/volunteer]

One care setting did suggest a little more information for staff, for example, a succinct explanation on a flyer.

> *… they would do their best to co-operate but they might struggle to understand what it was all about, so if they understood in advance… I mean, I have talked to some of the staff about this but they do a whole lot of things, the main thing is care, getting them up, dressed, and this is something that might need explaining to them.* [Care staff]

Museum staff and volunteers mooted the idea of a video. Training for care setting staff may help; a Wide Skies reminiscence training session in October 2011 included care setting staff. Two of the care settings involved went on to have successful reminiscence sessions. There is also something to be said for developing on-going relationships with care settings so that staff and museums can get to know each other and their respective needs. Most homes contacted, when asked, would prefer an on-going relationship with a museum.

7.3 Doing reminiscence

Reactions to objects taken to reminiscence sessions varied, however, many people talked about the need for multi-sensory objects

> *Really tactile things are good, for example silk stockings, things that smell for example a tobacco pouch. Of course, that's what our memories are, smells, taste and music.* [Museum staff/volunteer]

> *I might have even taken in something musical, to listen to. There was some singing. I was surprised that a couple of people who remembered very little remembered the words of songs from when they something were younger, either in a social setting or a church setting.* [Museum staff/volunteer]

Written materials, in some circumstances engaged residents, but could be problematic where residents were no longer able or have never been able to read. Sometimes flash cards and videos can be used and do have a role in reminiscence; these were not seen as quite as effective as multi-sensory objects

> *We get a better responses to objects, tea-parties and scenarios rather than video.*

They have place but are not as good as objects. [Health professional]

It was suggested that flash cards have pictures as well as words for those that cannot read.

The function of objects was seen to stimulate and enable conversation; particularly in the case of people with dementia.

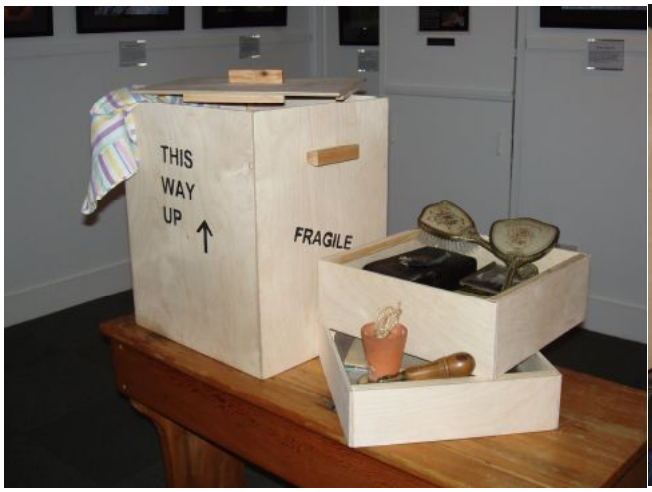
Using the objects people's faces light up, they give a visual cue. [Health professional]

This reaction was not confined to older people; it was mentioned in relation to an inter-generational session that took place as part of the Key Memories project.

Their grandparents had some of the objects. It was a good conversation starter. [Museum staff/volunteer]

One museum did raise the point that, care settings should be asked to check loan box contents for objects that might be hazardous to residents.

Most reminiscence boxes had themed sub-compartments; this made it helpful for larger groups as contents could be split up. Whilst some were plain containers, one museum designed a box that opened up as a display case, another in the shape of an old tea chest and another used vintage suitcases as containers. Whilst plain boxes are simple, cheap and practical (easily stored and carried), themed boxes add to the whole experience and lending it a sense of excitement and anticipation.



The 1950s kitchen cabinet display that was constructed for the Key Memories project and could more properly be described as exhibition rather than memory box, although it is semi-portable, splitting into several pieces and fitting into the back of a car. This cabinet, as discussed in the review of Key Memories, has seen sustained use, including in the training of care staff and is a popular piece of equipment – one care setting are

commissioning one of their own.

> *It had an immediate response because of how it looked and it reminded them of a piece of their own furniture* [Health professional]

> *Yes; it was very well liked when it was borrowed. People took an active interest in the everyday objects. [Care staff]*

> *I have borrowed it twice, it is a good resource and I plan to borrow it again every 18 months or so. [Care staff]*

Issues with the kitchen cabinet are that you need space to display it and store it and it is quite heavy. This is particularly difficult for day care settings that rent rooms and therefore cannot leave the display out.

Feedback from care staff resulted in the creation of the Wide Skies dressing table. Staff indicated that they wanted something more portable, and suitable for both for men as well and women. This is smaller than the kitchen cabinet, and whilst heavy, can be carried by one person in one piece. The dressing table was used at the observed case-study sessions and one resident in particular engaged well with it as an object by opening the drawers and touching the smooth panels (other residents were not able to reach it). It is early days for the dressing table but indications are that it is a popular resource which has had good reactions to it. In some cases, it should be used alongside other resources which provide an alternative to dressing up. In addition, groups need to be organised in such a way to be able to sit around it and access it themselves as part of the pleasure is interacting with it. Objects can of course be taken out to residents who may be sitting dispersed around the room but the dressing table is itself a little heavy to carry comfortably around from person to person.

> *The advice is to sit around a table with the dressing table, we did this once, but other times they were sitting in their lounges, so although we had the dressing table there, we had to hand out articles to each resident around room. [*Museum staff/volunteer]

The form in which the sessions were done varied, in some cases people were addressed in larger groups, in others people were sat around a table and often residents remained sat in chairs and museum staff or volunteers circulated around the room. The manner in which sessions were delivered depended both on the set-up in the care setting (it is hard to move people who are comfortably seated in familiar chairs), on the level of need of those involved and the number of museum staff. People with more advanced dementia needed more individual attention. A flexible approach and ability to think on your feet was considered important by museum staff.

> *You very much you have to make it up as go along depending on the type of audience. I've learnt to actually ask when I take the bookings, what the abilities of the audience are, so with the people who have dementia and Alzheimer's it's very much the case of just giving them the objects and then going around and talking to*

*each one, there is no way of doing a (group) session. Some of the day centres I've been to, then you can do sessions, introduce them and take them through it. [*Museum staff/volunteer]

As we went into the care home we were asked what kind of grouping we needed and I think the helpers there split people into little groups and we had got our boxes split into various categories and we went around, the two of us, into different groups and we passed things around and encouraged people to comment on what we had taken in. [*Museum staff/volunteer]*

With day care centres you work with larger groups, about 12, with residential centres it's very much one-to-one, to two or to three; it's much more personalised to individuals as there are more specific needs [*Museum staff/volunteer]*

Museum staff and volunteers interviewed as part of the case studies emphasised the importance of good staff ratios as, at least where there are people with dementia, it was a 'conversation' rather than a 'presentation'.

At least two museums combined reminiscence sessions with 'vintage' tea parties, along with original china. Museum staff baked cakes for one of these from old recipes, whilst the care setting provided tea. These were seen as very successful - the latter took place within the Key Memories project where there was an on-going relationship with the care setting.

Managing people within groups and ensuring they had a chance to talk can be difficult, equally, getting conversation going in smaller groups or one-to-one could be challenging.

*Last time I was there it was difficult because one had Alzheimer's, one didn't want to join in anyway and didn't really want to be there and someone else did all the talking… She was just sat on that topic; you couldn't shift her mind off it, you know…That's why it's better when you've got two of you on one table. [*Museum staff/volunteer]

*It's about being sensitive to people, if you have someone who is quiet, to try and bring them out. There are sometimes people asleep, you need to just go with it and not force it. [*Museum staff/volunteer]

7.4 Training

Many of the issues discussed above were covered by training sessions that were held throughout the project and there was positive feedback from these (although not everyone doing reminiscence had been on training)

I found that extremely useful actually, as I haven't had experience of going into care homes before and the ideas they gave us, particularly for people with

*Alzheimer's or Dementia were useful, very useful. I've learnt on the job as well. [*Museum staff/volunteer]

*I used to be caring for my ill mother and mother in law, I remember remarking at the time I wished I had had the training before that had happened, because it kind of put it into perspective and explained things which I wasn't always sure of. [*Museum staff/volunteer]

*The training was excellent in developing box and delivering reminiscence. [*Museum staff/volunteer]

In some cases, however, it was felt, that there was no need for training and an individual's life experience was sufficient

*We go to training, to be truthful, ladies of about 60 who are interested in it anyway… I suppose they need a bit of training, but not to any great extent [*Museum staff/volunteer]

This may well be the case, especially where individuals have experience dealing with people with dementia, however it might be that in some circumstances, some of the ambivalence about the purpose of reminiscence felt by some people (discussed in this chapter) could be avoided through an understanding of the theory about reminiscence, its potential benefits, and about the processes of memory loss. Training also covered other issues, for example, what to do in the case of a resident getting upset through the recollection of unpleasant memories.

It isn't just talking to someone is it, because you need to understand why you are doing it and the benefits it can have. [Health professional]

However, training is only the start, with skills being gained through the actual doing.

They have more understanding and coping ability if they have had some training. In a sense it is only basic training as reminiscence is learnt by doing it and that is very hard. [Health professional]

*… you improve and hone your skills in your approach and this is to do with active listening. With more experience you gain more skills. It's not necessarily what you say but is about listening and maybe prompts every now and again. That does take confidence… it's the confidence of not saying something for a while and letting someone think through something, especially if they have dementia [*Museum staff/volunteer]

7.5 The future

Four of the five museums in the Key Memories project have continued to deliver reminiscence sessions. A number of museums in both projects are keen to maintain or develop reminiscence services. Sustaining reminiscence is, in part, related to the

commitment of a museums staff, volunteers and management, but it is also a capacity issue for paid staff. It is likely that the delivery of reminiscence through external freelancers (although successful) has made it harder to sustain at the end of a project.

> *Staff there are passionate and want to do more [*Museum staff/volunteer]

Contact between care settings and museums in the Key Memories project was lost in all cases (although in one case it was resumed through the Wide Skies project) yet care settings would have welcomed continued contact. There does, in fact, appear to be an appetite from care settings for services from museums. Most museums do, however, offer this service either for free (through Wide Skies) or for little cost at present which is probably an added incentive.

The role of coordinating reminiscence activity in the projects being evaluated was undertaken by staff who work very part-time hours or who are voluntary. Reminiscence sessions take some organising and can also involve recruiting and managing volunteers; this takes a committed, skilled and capable individual, whether paid or unpaid.

There are different models for delivering reminiscence activity, from providing loan boxes to doing facilitated sessions which can be delivered to a range of audiences - from social activities in pensioners clubs to therapeutic sessions for people with dementia. To do the latter consistently and well takes resources and effort, particularly when participants have dementia. Loans boxes while requiring fewer resources, still require input, for example the need to produce quality boxes with instructions and to publicise them. Whether museums should do reminiscence and the delivery model they decide to take will depend on their own priorities and resources. Central facilitation such as with the Wide Skies project or a joined-up approach with other museums (perhaps with one museum taking a lead as a 'specialist') and the involvement of other partners, for example, the NHS or library services, may also be ways forward.

> *I believe one size does not fit all and it is to do with museums and their resources and capacity. For some museums, if they have a volunteer who goes out, it would be constructive if they develop a good relationship with the centres or homes rather than going to lots of different ones... It is better doing quality work with a small number rather than hitting lots of different ones. [*Museum staff/volunteer]

The key issue for some museums for the future was assistance with marketing; a publicity brochure has just been produced and distributed through Cambridgeshire Museums Partnership, which may provide a solution

> *I think the marketing is crucial, we have to make up our own lists and it's not always easy, many of these care homes, for example, you can't always find their email. So if that was done on a centralised basis offering services from a range of museums near to that care home, that would be hugely beneficial. [*Museum staff/volunteer]

*We have to be careful not to overlap and for museums not be in competition. There needs to be a planned approach to marketing, it has got to be developed and the Wide Skies project can help. [*Museum staff/volunteer]

The other potential issue for the future sustainability identified by museums was recruiting sufficient volunteers.

Publicity Leaflet

8. Cost of provision

8.1 Costing a session

Five museums were asked about the time they normally spent organising and running a reminiscence session and this information has been used to estimate costs.

Hourly staff rates are those suggested by the Heritage Lottery Fund[31] as equivalent costs for volunteer hours i.e. £150 per day for skilled staff (people leading workshops for example), and £50 per day for unskilled staff[32]. Reminiscence session organisers were volunteers in two of the five cases; assistants were always volunteers.

The number of volunteer assistants varies; sometime the organiser went on their own, at other times with up to two assistants. Occasionally there were care staff or family members available to help, otherwise, larger groups were split down into smaller groups which were visited in turn.

Tasks	**Main organiser**	**Per extra assistant**
	Hours	**Hours**
Organisation and planning	1.75	-
Travel	0.50	0.50
Session (may include tea afterwards)	1.50	1.50
Setting up / clearing up	0.50	0.50
Total hours	**4.25**	**2.50**
	Costs	**Costs**
Assumed costs per hour	£20.00	£6.60
Per session	**£85.00**	**£16.7**
Travel for 10 miles	£10	
Total costs (not including refreshments)	**£95**	**£16.7**

The calculations above give an indication of what it may cost to run sessions, or

[31] Heritage Lottery Fund (2009) '*Thinking about...Volunteering*', http://www.hlf.org.uk/howtoapply/furtherresources/documents/thinking_about_volunteering.pdf (viewed 20th January 2012)

[32] It has been assumed that equivalent volunteer costs for skilled staff will be equally applicable to paid staff.

equivalent costs where volunteers are involved. In the latter case, whilst wages are not paid, the sessions still have other costs associated with them, for example, travel and office overheads. Currently, where museums in Cambridgeshire do charge for sessions, it tends to be somewhat less than the estimated figures above and in the range of £30-50.

8.2 Costing a reminiscence box

Resources: Museums estimated material costs from £10 - £250. Key memory museums had budgets of £250 per box.

Time: Time estimates for putting together a box varied from 5hrs to 3 days.

Taking an average of estimated costs and time and assuming the input of skilled staff, would result in boxes costing £393 (£127 for resources, £266 for skilled staff time).

Thus, if a memory box is lent out twenty times in the course of its life, a £20 fee would be needed to recoup costs, not including repairs and staff time in organising the loans process. If the latter were taken into account the true cost would be greater than this.

Where there are no staff costs involved in creating a memory box these figures would be substantially less.

Where museums do charge, it tends to be between £5-10 per week for a box, with monthly charges varying between £15-35

8.3 Key Memories funding

The Key Memories project involved a number of different activities and this makes estimating the cost of reminiscence activity alone difficult. The headline costs of the project are given in the table below - Section 1 represents those elements of the project that can be identified as stand-alone, (normally) central costs. Section 2 includes those costs associated with organising and running one intergenerational session, creating two memory boxes, running five reminiscence sessions and collecting oral history records (whilst doing reminiscence sessions). The latter averages out to £5,554 per museum which would indicate that the various elements of this project are relatively expensive, especially when the costs per reminiscence session calculated above are taken into consideration. In the latter case, however, no allowance was made for non-direct, external costs, such as training and support. All of these museums have had support through either Key Memories or Wide Skies projects to help kick-start reminiscence activity. Starting a new activity is expensive, it is only when it is routine and embedded that costs come down, even so, costs are often underestimated as the full costs of running services (such as on-costs, recruitment and training) are not always taken into account.

Section 1:Stand alone costs	£
Buddy training (to recruit new volunteers for the future)	563
Contemporary items for museum collections	361
Delivery of touring exhibition	723
Freelance fee for exhibition design	1,225
Touring exhibition design and manufacture	1,750
Sub total	4,622
Section 2: Oral history, reminiscence and intergenerational	
Staff costs inc freelancers	21,222
Stationary	188
Training and support	3,386
Travel	579
Oral history equipment	417
Reminiscence box items and construction	1,766
Reminiscence session refreshments	213
Sub total	27,771
(£5,554 per museum)	
Total	32,393

9. Conclusions and recommendations

9.1 Conclusions

While further research is needed, there is an emerging body of evidence that reminiscence can contribute to positive outcomes for older people and people with dementia. In this evaluation, residents in one of the observed sessions had very high well-being scores; they were often actively engaged and spent time interacting with each other and with museum staff/volunteers. In all of the sessions, wellbeing was generally good and often high, particularly when participants were actively involved in reminiscence.

Care setting staff and museum staff/volunteers in this evaluation valued reminiscence activity. Both saw a role for museums through the provision of resources or facilitated sessions. Care settings appear to welcome contact with museums because, while they can and do deliver reminiscence, they often saw museums as experts in interpreting historical objects. They also felt that volunteers and staff provide 'fresh faces' to residents and may be particularly suited to this work due to an interest in history and in people's stories. Care setting staff may also have limited time to spend with residents. Some care settings felt their staff could improve their reminiscence skills through attending sessions delivered by museums.

Most care settings preferred facilitated sessions as opposed to loan box schemes (although these are valued too) and also preferred on-going contact with museums. Delivering reminiscence sessions in care settings take time and effort and it is an achievement that small, sometimes entirely voluntary-run museums are able to deliver this activity at the level they do. It may, however, be hard to sustain in the longer term without support.

Volunteers and museum staff can demonstrate high levels of skill when reminiscence is done well. They are not always conscious of the levels of skill they demonstrate or the contribution they make. Doing reminiscence can be emotionally draining on occasions and it can be difficult to do, however, sessions are often be upbeat and enjoyable. Museum staff and volunteers normally find it rewarding and satisfying. Managing, recruiting and supporting volunteers to deliver reminiscence sessions takes skill and time.

A tradition of collecting oral histories in the museum world can occasionally lead to feelings of unease that information from residents is not recorded and a sense that people's memories were therefore not being respected. This may one factor leading to occasional ambivalent feeling about reminiscence and its purpose among some volunteers.

Training is highly valued by most people, however some people consider life experience sufficient preparation. Training can clarify the aims and intended outcomes of reminiscence and help prepare staff and volunteers for difficult situations.

Procedures for vulnerable adult protection do not appear to be specifically addressed although this may be a part of more general training for staff and volunteers.

There are a number of ways of delivering reminiscence sessions depending on the level of capacity of those attending. Good prior communication with care settings is needed for a successful session, as is a level of flexibility on the part of the museum. Even with prior communication however, care settings do not always understand the requirements for delivering a good session.

Volunteers and staff stressed the need for good ratios of staff/volunteers to residents in a care setting environment. Physical 'set-up' can influence outcomes and small groups of residents to work well, especially where there is also individual support and one-to-one interaction. Each session and situation is unique however, so a level of flexibility (and guidelines rather than a prescribed method of delivery) is probably the best approach.

Objects are prompts for promoting conversation and memories. The best reminiscence objects should be multi-sensory or encourage interaction or action e.g. the trying of hats. There should be sufficient breadth of objects to engage a range of people and it should be remembered that not everyone can read printed materials. Objects should be laid out so that participants can pick up what attracts them rather than being handed objects. Staff and volunteers need background information on some objects in order to stimulate conversation.

The Key Memories successfully achieved almost of its outcomes, the travelling display was particularly successful and most museums are still involved in reminiscence. On-going contact with care settings was not been maintained. Wide Skies is in early stages but has already exceeded its targets for Reminiscence. Evidence from Key Memories and Wide Skies indicates that the presence of a central facilitator encouraging and supporting museums to deliver reminiscence does appear to increase this activity; especially sustained contact with care settings.

The amounts of money currently charged by museums to care settings, when a charge is made, do not normally reflect the true costs of provision.

9.2 Recommendations

Museum-led reminiscence activity has valuable outcomes for museums, care settings and older people, it should be encouraged where possible, however, museums should realistically assess the **time, effort and costs** needed to run **quality reminiscence services** and, where it fits their priorities, select a suitable model to fit their capacity.

The case studies **vividly illustrate** how factors in the delivery of reminiscence **impact on outcomes** for residents, particularly having adequate **staff ratios** for the

participants' **level of need**, room set-up and the range and presentation of objects. The case studies illustrate both the benefits reminiscence can have for people in care settings and the challenges it presents, even to experienced and accomplished facilitators. Delivery of these services to people with a higher level of need is particularly challenging. Where this is undertaken, there should be a focus on refining and developing services to maximise outcomes, possibly by concentrating activity at those museums that have this as a particular focus and through the development of relationships with care settings. 'Social' reminiscence activity (i.e. to those without special needs) and loan boxes provide a less resource-intensive method of delivering reminiscences services.

The purpose of reminiscence also needs to be clear and the therapeutic benefits expressed as outcomes for the individual (e.g. improvements in wellbeing, opportunities to counter social isolation) in order that there is shared understanding of its aims. These aims and the key findings from the case studies should be **communicated** to museums and care settings involved **in a suitable and practical format** (bearing in mind most staff do not have time for lengthy reading), for example, a good practice flyer, poster or video.

Mechanisms could be created to maintain relationships between care homes and museums. Continued opportunities for care staff to receive reminiscence training and participate in delivering reminiscence sessions are likely to **assist partnership working and improve the quality of the sessions**.

Arrangements should be put in place so there is the **chance for all staff to debrief** about sessions that feel both 'positive' and 'negative'. Opportunities for volunteers and museum staff to further develop their skills, for example through reflective discussion, could be considered. It may benefit all parties to review a volunteer's involvement after an initial period to ensure that they are properly supported and that they are suited for this type of work. **A mechanism for evaluating / monitoring the quality of session could be considered.**

The issue of vulnerable adult protection training and criminal record bureau checks needs further clarification.

Central support is likely to be needed to continue to facilitate some aspects of reminiscence, for example, training. It will probably be difficult for small museums to **sustain this type of activity** without support and options should be explored, for example, partnership working (with other museums, libraries, social services or the NHS), funding for a central facilitator or the creation of lead museums.

9.3 In summary....

Reminiscence services can be delivered at a number of different levels, from loan boxes, to 'social' reminiscence and reminiscence with those with a high level of need.

Not all museums will wish to focus their resources on delivering reminiscence sessions in care settings. Individual museums should realistically look at the cost, effort and their own priorities when considering this issue. Reminiscence activity is, in many ways, a perfect fit for museums wanting to engage with the wider community and can bring tangible outcomes to vulnerable groups. Where it takes place, the involvement of museums with care settings also has the potential to influence practice. Museums have not only the resources to deliver reminiscence, but the volunteers and staff with an interest in people's stories and the knowledge of interpreting objects. The question is, whether museums, especially small, voluntary museums, have the capacity to sustain quality reminiscence services in the longer term, what model they should adopt, and how training and other resources will be funded.

10. Appendix 1: Informants

Key Memories projects

Interviews with

- All five project 'leads'
- Two curators (where project leads had moved on and in order to ascertain what reminiscence had taken place since the end of the project).
- Three volunteers (other volunteers were no longer in contact with the museums).
- Brief phone calls with all five care settings that worked with the museums. Although in a number of cases the member of staff involved in the project had moved on, this was done to see whether reminiscence boxes left with the care settings were in use.
- Brief phone calls with three care settings that had used the Key Memories 1950s Kitchen Cabinet display.

Paper documentation

- HLF documents (application and reports)
- Reports from museums, although these were, in most cases, very brief.

Wide Skies Project

- Electronic questionnaire to all nine museums in October 2011
- Telephone interviews with two museums
- Evaluation forms from training at Octavia Hill House in October 2011 and follow up emails in December 2011
- Two interviews with Wide Skies Coordinator
- Dementia Care Mapping and case study of reminiscence sessions
- Interview with two care settings that had hosted a Wide Skies reminiscence sessions

Paper documentation:
Wide Skies HLF application and financial breakdown

Over-arching and Challenge Fund

Telephone interviews with

- Three individuals from Cambridgeshire and Peterborough, NHS Foundation Trust Older People's Service
- Museums Partnership Officer, Cambridgeshire Museums Advisory Partnership
- Dementia Services Director of a care home chain
- Freelance Reminiscence Trainer.

Paper documentation
Challenge fund financial breakdown and final report