

## **LEARNING PROCESSES IN CARE HOMES AND THEIR EFFECTIVENESS**

In 1999 the British Geriatric Society held a conference “Teaching in Care Homes”. There has also been a small number of published reports on this topic. And the British Medical Journal has recently published a series of articles on the effectiveness of different methods of clinical training.

This document is a collation of key extracts from these various sources. A fuller version is available from NHS Greater Glasgow (see below) and the original papers are identified in the references section.

### **The problems**

Present forms of regulation do not give proprietors and staff of Homes sufficient support in setting and raising standards. People do best when working for their own self-respect and job satisfaction rather than merely meeting lists of rules or preparing for occasional visits from overworked regulators. There can be little doubt that supplanting a regulatory framework by a research-based culture of self-evaluation will be of benefit to all. (Grimley Evans)

The elderly with multiple problems and chronic incapacities can no longer turn readily to a truly dedicated specialist in the complex area of old age pathology and multiple system medicine. In consequence, not enough specialist training, teaching or research work is being pursued in this area. (John Wedgewood & Arup Banerjee)

There is a perceived lack of information as to what residents can expect from care staff. Conversely, care staff frequently do not know what is expected of them. The lack of training is evident and is needed at all levels. (Kate Avebury)

The problem we are addressing is essentially the lack of creativity, a shortage of innovation, the potential for premature regulation and restriction of options, a preoccupation with structure and process as opposed to outcomes, and a failure to define and measure the outcomes we wish to pursue. (Robert Kane)

It is a paradox that older people with the greatest need for consistent, creative and effective care now live in care homes denied the traditional essence of interdisciplinary geriatric care. (Hockley)

Increasing numbers of deaths in nursing homes puts mounting pressure on both trained and in particular untrained staff. This pressure of work and the lack of any real support of staff may well be one factor for low morale in care homes (nursing) and the increasing staff turnover. (Hockley)

### **What staff need**

Staff must be supported by experienced practitioners who work with them and should be encouraged to seek information, help and advice from them. Experienced

practitioners should “infiltrate the organisation at all levels, building relationships with residents, carers and staff”. (Linda Dowell)

Staff must be encouraged to make referrals to specialists where necessary. Specialist should be regarded as a crucial resource, and their visits used as an important opportunity for staff training. Staff should feel free and able to suggest to Management that additional specialist help can be called in whenever they feel there is an evident need. (personal observation)

Staff should also know what facilities and opportunities are (or should be) available both outside and inside the Home, and should promote and facilitate their use by residents. (personal observation)

Staff need to understand what more can be done for residents – for example in terms of symptom management, (re)habilitation, nursing, medical and dental care, opportunities for meaningful activity. What would staff want their situation to be if they were to change places with their patients. (personal observation)

### **What residents can contribute**

It is important to sensitively elicit the needs, wishes and aspirations of each resident and to keep in mind the dignity and self-esteem of these residents. Residents themselves have experience and skills which should be used and encouraged by the staff. (Linda Dowell)

Residents need continuing (weekly) assessment – not 6 monthly. All staff need to think imaginatively about what can be done for each resident: potential for improvement. (personal observation)

### **New thoughts for training**

We should change the emphasis from theory to work-based learning practice, develop supportive and challenging care environments and create a culture where practice is challenged and constantly re-examined. (Brendan McCormack)

Teaching should not only equip practitioners with knowledge and skills but also foster their attitudes and encourage good practice. The ultimate aim of improving care could not be achieved with changes in knowledge and skills alone – it would also require changes in attitudes and behaviour. (Coomarasamy & Khan)

Training per se requires further evaluation. We believe training is a good thing but there is little evidence about what difference training makes. We need more research into its effects. Is there any correlation between staff training and the quality of care delivered? (Rudolph Klein)

Creating career paths for care assistants might be a good investment; also spending more time interviewing staff, rather than patients, to find out what factors influence morale and translate to better quality care. (Rudolph Klein)

In addition to learning from experienced practitioners and specialists 'on the job', some more formal educational experiences are necessary. Self directed learning, lectures and even tutorials are not much liked. Consideration should be given to reflective practice; questioning one's knowing and understanding of practice is an integral aspect of reflection. (Linda Dowell)

Good use could be made of videos (of good and bad practice), group discussions and role-play case scenarios. Rotation of staff (junior as well as senior) on a temporary basis between Homes is also effective. Protected time is essential for training purposes, and where possible training should be multidisciplinary. (Linda Dowell)

Without reinforcement in subsequent practice, even the modest knowledge gains from standalone courses and workshops are likely to deteriorate over time. Education received in this way is unlikely to lead to any meaningful changes in clinical care. Only clinically integrated teaching is likely to bring about changes in skills, attitudes, and behaviour. Teachers must bring teaching out of classrooms into the clinic. (Coomarasamy & Khan)

A systematic review shows that integrating teaching with clinical practice is vital to improving attitudes, skills and behaviour. Integration means addressing real and current clinical problems. Thinking is not enough and doing is necessary for success. (del Mar, Glaszcau & Mayer)

### **What is needed from the Care Home?**

There is need for a vision: what can or could be achieved in the Home. Good morale, self-esteem, understanding and valuing each others roles are essential. (Linda Dowell)

For a long-term, effective outcome from educational and practice development initiatives there must be involvement and commitment from nursing home owners and managers. (Katherine Froggatt)

### **Policy implications**

Each geographical district needs a network of collaborating institutions spanning the statutory, charitable and private sectors with a co-ordinating centre. Formalised training programmes should be provided for all grades of nursing and residential home staff. Co-operative research and development will need to be organised across participating sites. (Grimley Evans)

Active proposals to demonstrate how best to promote and deliver quality training in long-term care need to be disseminated far and wide. (Kate Avebury)

## References

*Proceedings of a joint British Geriatrics Society and RSAS AgeCare conference held on 11<sup>th</sup> February 1999.*

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*What is the evidence that postgraduate teaching in evidence based medicine changes anything? A systematic review: Arri Coomarasamy, Khalid S Khan. British Medical Journal, Volume 329, 30 October 2004, p1017-1019.*

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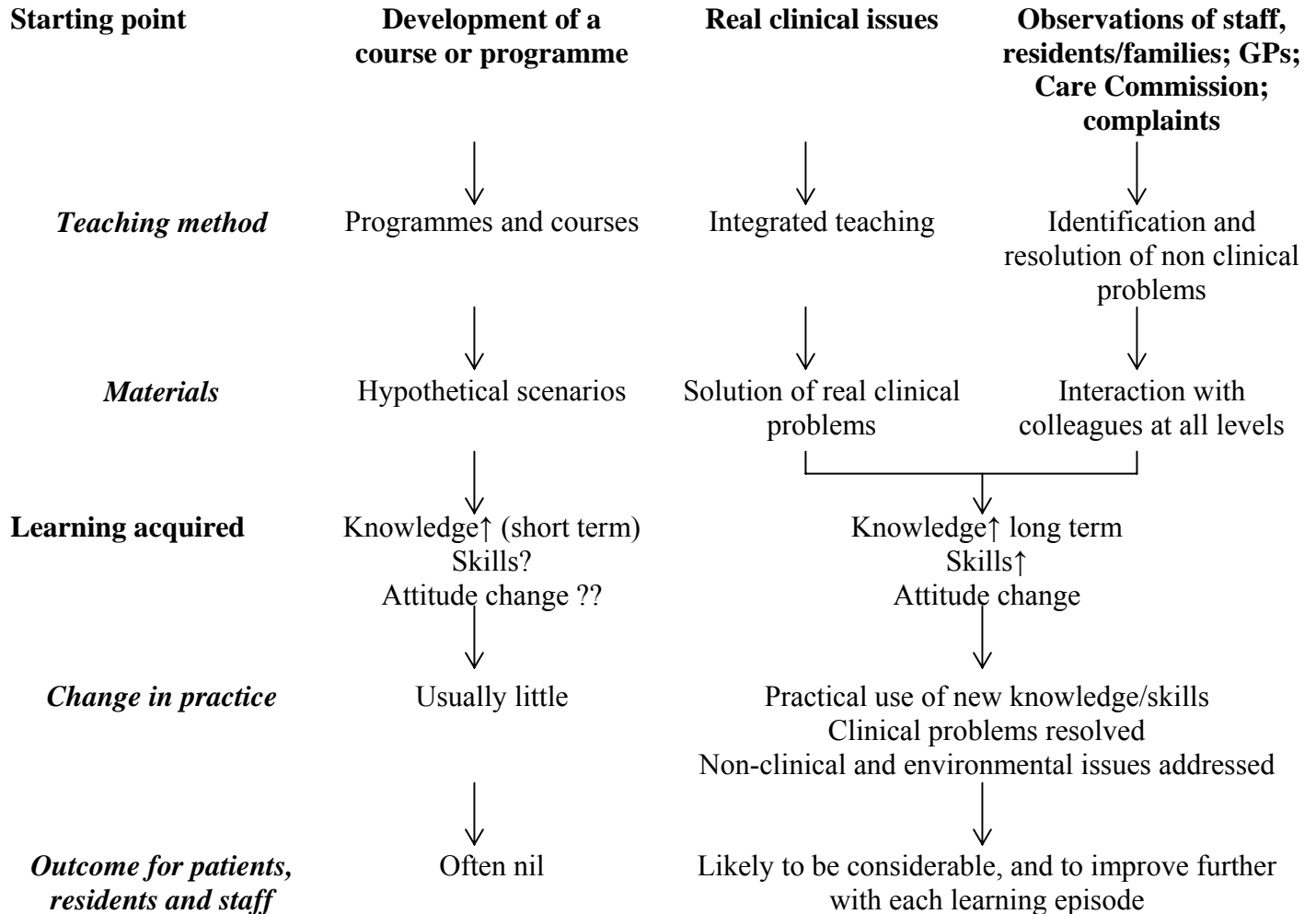
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# CLINICAL LEARNING PROCESSES AND THEIR EFFECTIVENESS

Annex 1



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