

Learning Opportunities for Nurses and Care Assistants in Care Homes

Introduction

If care home staff are to work to a high standard they need opportunities to learn and develop their skills; they also need respect. Concern has been expressed both locally and nationally about these issues - about the effectiveness of 'training' and about morale.

In order to investigate the situation locally, funding from the Big Lottery has been used to set up a team of individuals that has worked part-time in a number of care homes in the Glasgow area over a period of 30 months. The team comprised a clinical nurse specialist with experience of managing a care home, an activities co-ordinator with a research background (and her assistants), a senior I physiotherapist and occupational therapist, a more junior speech and language therapist, and a holistic therapist (Reiki, aromatherapy) plus a nutritionist. Team members worked for half or a full day of week over a period of at least six weeks in any one home. Usually only two team members were present in a home at the same time: partly to minimise disruption to the routine, but mainly to maximise involvement of nursing staff and care assistants.

The two key objectives were firstly to help residents to reach their full potential in terms of physical, social and mental function, and secondly to enable and encourage nursing staff and care assistants to take on this responsibility between visits from the specialist nurse and her therapist colleagues.

The Big Lottery Care Home Team: operating principles

The work was guided by the following principles:

- Agreement with care home managers (including in some cases at senior company level) about the purpose of the proposed work
- Engagement with the nurse manager for each care home, and where possible continued active involvement
- Engagement with the relevant general practitioners in the Nursing Home Medical Practice
- Participating in the day to day work of nurses and care assistants in each home: in order to experience their problems, share ideas and learn about their knowledge, skills and aspirations
- Providing basic training programmes(eg mouth and skin care, communication, oral health, nutrition, PEG feeding, syringe drivers etc.) for staff in all shifts, ie including evenings, nights and weekends)

- Encouraging ‘cross fertilisation’ of experience, ideas and development plans between team members and with care home staff
- Developing multi-disciplinary working – for example between nurses and the physiotherapists and OT; between the physiotherapist and OT and SLT; and between the physiotherapist and complementary therapist
- Encouraging goal-setting and outcome measurement - particularly for younger residents
- Generating a culture whereby care assistants and nurses in the home continued to provide rehabilitation interventions between visits from the therapist(s)
- Promoting an ethos of activity, and of residents doing things for themselves, rather than focusing on providing care and support (of particular importance to younger adults)

Big Lottery Care Home Team: principle findings

- ❖ Care Home managers are very willing to collaborate. Once trust has been established (by demonstrating that the aim was to help rather than inspect or criticise), staff are very willing to communicate: to discuss problems, suggest solutions and to generate ideas
- ❖ Nursing staff and care assistants are keen to learn, and were very appreciative of the improvements to residents wellbeing that resulted from the interventions by team members
- ❖ The needs of younger adults with a disability and of older people towards the end of life are very different. Younger adults need a stimulating environment, more and more challenging lifestyle opportunities and staff with different skills and attitudes
- ❖ Creating a learning environment in a care home is not difficult to achieve. Specialists such as a physiotherapist or a nurse who visit the home on a regular (eg weekly) basis are ideal for this responsibility, supplemented by ‘ad-hoc’ input from others.
- ❖ Learning in the workplace – from experience with individual residents – is very effective in improving practice. Teaching in a classroom situation has little or no influence on practice
- ❖ Good communication between staff and residents, between staff and visiting specialists and between staff within the care home (including day, night and weekend workers) is essential. On several occasions residents have remarked that team members conversing with them is unusual. Residents’ needs can only be determined after satisfactory rapport with them has been established – and certainly not from a checklist

- ❖ With some training and encouragement care assistants and nurses in care homes are very willing and able to continue with simple interventions between visits from therapists.
- ❖ Where an ethos is established of encouraging independence for residents and providing learning opportunities for staff, the care home becomes a rewarding and desirable setting to work within. It then becomes possible to attract and retain staff, and would be a first step in making care home experience a positive attribute (for example on a CV) rather than a stigmatising one as it sometimes can be. Encouraging care staff to join the Royal College of Nursing is also a way to make people feel valued and needed. It gives them support and options for training with hope of career advancement instead of seeing themselves in a low esteem, poorly paid, 'dead end job'.
- ❖ Working in a care home with the appropriate ethos is a valuable learning experience for nurse, professions allied to medicine and others: both during training and in the early years thereafter.

It is very important that nurses and care home assistants in care homes are aware of all the outside agencies and experts available to provide advice, interventions and other support for residents. In most homes there is very limited knowledge of sources of help and of how to access them. A list of some of these specialised services is attached (Annex 1). In order to make most use of these services all staff need to be encouraged to be on the look out for problems, and need to know how to make the necessary referral (usually through the general practitioner).

Other Evidence

There is a considerable body of evidence, relating to training/learning opportunities in Care Homes. In 1999 the British Geriatrics Society held a conference "Teaching in Care Homes". There has also been a 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. Key extracts from these and some other documents are given in Annex 2, and these may be summarised as follows;

- Learning should be continuing: from induction through one's career pathway.
- Learning is more effective in the workplace – when related to the individuals for whom the member of staff has direct responsibility. Staff members should have direct responsibility for specific 'residents'; really getting to know them, advocating for them and providing feedback about them
- Learning should take place during all contacts with specialists who come into the home to see residents. Every such contact should be a learning experience for staff, and staff should be involved in formulating and implementing care plans for residents (see Fig1)
- Although most effective in the workplace, learning should be supplemented by occasional (eg twice per year) group sessions outside the Home: for the

exchange of information and ideas, demonstrating good practice and networking with others to boost morale

- Learning will only be effective if staff are respected, communicated with effectively by their seniors, and given satisfactory feedback about their performance and the outcome of referrals for their Residents
- Learning should comprise a range of opportunities - including induction 'training', self-instruction, workplace learning, focus groups, reflective practice and some formal instruction; leaving new staff in front of a teaching video alone is not enough
- Learning must include issues which are of fundamental importance to residents – eg the importance of communication with residents (and their relatives), respect and maintaining dignity at all times, and the need for meaningful activity and outings

Annex 3 gives some extracts from a book by Julia Neuberger (2005) which collaborates the unsatisfactory treatment of care assistants in care home, and suggests ways in which their situation (and status) could be improved – to the considerable benefit of residents.

Annex 4 gives a selection of key messages from two working groups on Allied Health Professional support (including the Training Team) to care homes, and from a recent report on care home nursing by the Royal College of Nursing, Scotland.

Conclusion

There is more than sufficient evidence, both local and national, on which to base the development of an efficient and effective therapeutic rehabilitation combined with training facility for care homes. The key element would be regular (eg weekly) input to care homes where residents are most in need of therapeutic interventions – particularly where there are young adults. Their input could be provided by re-deployment of the PAM Training Team to provide training as part of clinical interventions, with additional contribution from the members of the Community Physical Disability Team.

Annex 1

Integrating Specialist Input with Learning in Care Homes

There are three groups of specialists who engage with Care Homes and who could provide a major learning opportunity for Staff:

(1) Specialists employed specifically to train Care Home staff:

- Allied Health Professional Training Team
- Two Care Home facilitators (1xNorth and 1x South of the City)
- Care Home Activities Team (Big Lottery funded)
- Art in Hospital (Barbara Gulliver)
- Complementary Therapists (small resource, Big Lottery funded)
- Scottish Huntington's Disease outreach worker
- Palliative care nurse specialist (North/East of the city)
- Project manager(Big Lottery Fund, temporary post, non malignant palliative care)

(2) Specialists with a specific responsibility for Care Homes who have potential to adopt a training role:

- Nursing Home Medical Practice and other GPs
- IRIS Nursing Staff (North/East of the City)
- Care Home Liaison Staff (South of the City)

(3) Other specialists who work in care Homes from time to time and who could inform and train staff concurrently with their clinical intervention(s):

- Community Physical Disability Teams
- Acquired Brain Injury (non alcohol related)
- Alcohol Related Brain Injury
- Community (health Centre) based physiotherapists and SLTs
- Consultants in Rehabilitation Medicine (Physical Disability Rehabilitation Unit, Southern General Hospital)
- District Nurses
- Nurse specialists in palliative care, mental health, continence care, tissue viability, multiple sclerosis, epilepsy and Parkinson's Disease
- WESTMARC wheelchair and appliance service

Interaction between care home and visiting professionals

Whenever specialists such as those identified in (2) and (3) above make contact with a Care Home resident, the care assistant and nurse with most direct responsibility for that resident should be fully involved in the consultation This would enable them to learn from the experience and to discuss with the specialist the Care Plan and specific interventions required. Where appropriate the care assistant, nurse (and when possible resident or family), should be provided with enough information to enable them to provide continual assessment and intervention for the resident in order to achieve the

maximum benefit from the specialist visit.

The benefits of this interaction would include:

- Care Home staff fully involved in establishing and putting into practice the Care Plans
- Valuable learning experience for Care Home staff (and often also for residents)
- Enhanced working practices and higher morale of Care Home staff

In order to enhance and structure learning opportunities:

- Staff should be encouraged to identify residents with new problems or for whom there is concern, and to refer to the next most senior person; also to ask questions and to question the suitability of care. In other words staff should do their best for residents - as they would do for their own relatives (see Annex 4).
- There should be a career pathway for each member of staff - certificates of accomplishment (not attendance!), a little extra pay (cf. mental health services), to SVQ's and progression towards a nursing career if sought.

Staff should be given additional responsibilities, such as:

- writing in case notes
- providing continuing simple interventions / rehabilitations under the direction of a physiotherapist, speech & language therapist, complementary therapist or arts therapist
- creating a commendation book
- developing expertise in a particular area – eg care of residents with continence problems, multiple sclerosis, parkinson's disease or dementia

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Annex 2

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 Banergee)

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. Specialists 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 11th February 1999.

Training for staff in Care Homes and hospital facilities for people who need long-term care and support. Linda Dowell: 'Multiprofessional palliative care: education and training needs'. International Journal of Palliative Nursing, 2002, Vol 8, No 6, pp 294-303.

Palliative Care Education in Nursing Homes. Dr Katherine Froggatt, McMillan Cancer Relief, April 2000.

Death and Dying in Care Homes (Nursing): A Postal Survey. Jo Hockley, NR SCM MSc, St Columba's Hospice, Edinburgh, UK.

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.

Teaching Evidence Based Medicine. Chris del Mar, Paul Glaszcau and Dan Mayer. British Medical Journal, Volume 329, 30 October 2004, p989-990.

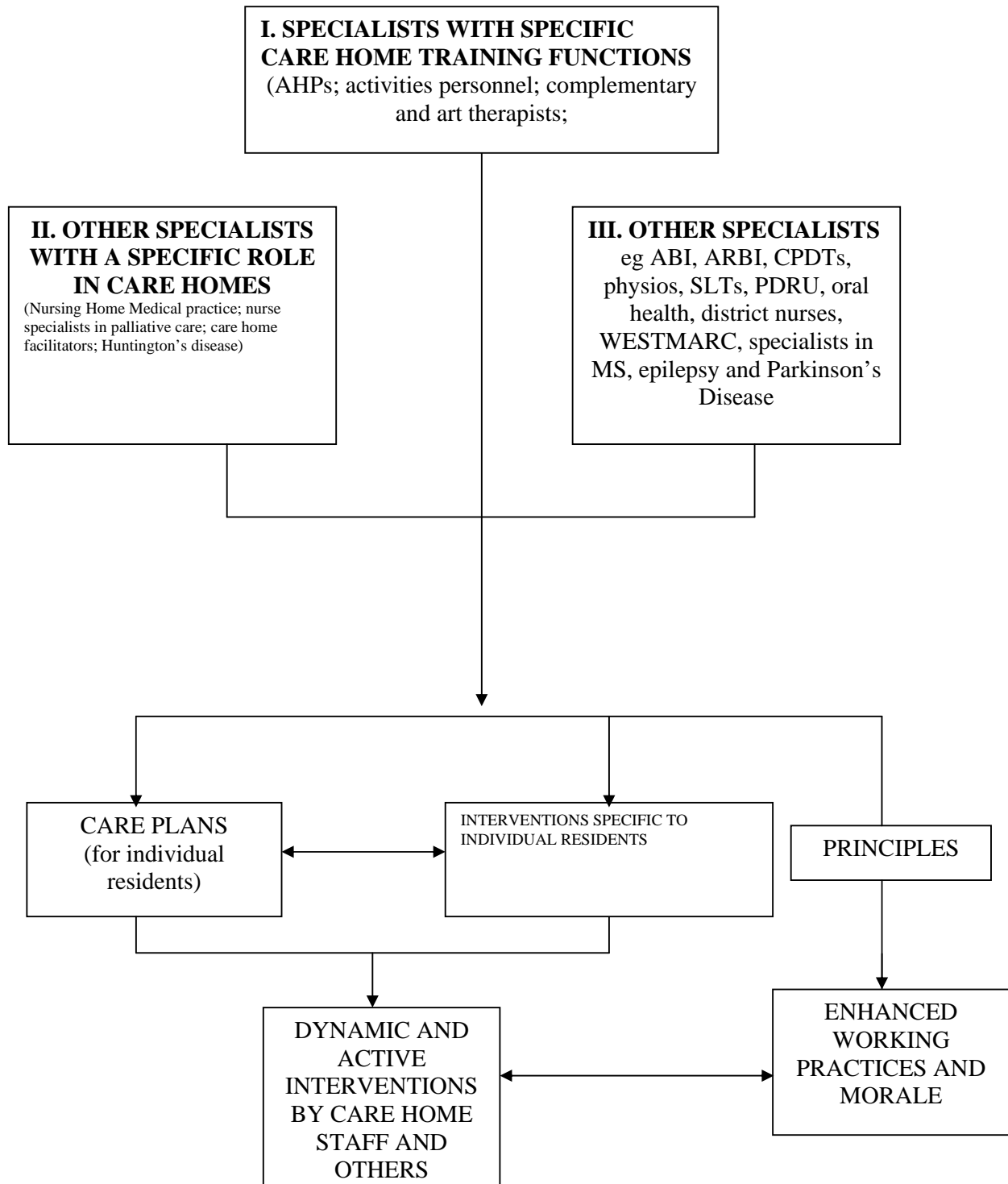
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Fig 1

Integrating Specialist Input with Learning in Care Homes



Annex 3

The Status of Staff Working in Care Homes

Wage levels for different groups of workers are a good reflection of the value placed on them by society and care workers in Care Homes fare particularly badly in this report. Many care workers and nurses continue to work in Care Homes because they rightly see their work as valuable and rewarding and are prepared for this reason to put up with hard work, low wages and often lack of respect.

However this is not a situation that should be allowed to continue; for many staff their poor treatment leads to low morale and hence to poor performance. The Royal College of Nursing is currently campaigning for better treatment for all staff who work in Care Homes, and its efforts should be widely supported. Julia Neuberger also has legislated the need for much improvement in the status of care workers in Care Homes, as the following extracts show:

“Basic hands-on procedures, are increasingly undertaken by care assistants whose training is often minimal and whose security of tenure, and relationship with other members of staff, tends to be poor.”

“Nurses are now too expensive a resource to be allowed to feed patients, make beds, or plump up pillows and are too busy giving drugs and injections to empty bedpans. Nor have they been trained to talk to patients and find out what is really worrying or concerning them.”

“Care assistants do not have the status to allow them to tell relatives and social workers what is worrying a patients. It used to be said that the people who knew most about what the patients were really feeling were not the nurses at all but the cleaning staff, who would chat to patients while they mopped round their beds.”

“Were assistants were actively encouraged to study for NVQs and then, where appropriate, to move on to more advanced qualifications, the whole atmosphere might change. Care assistants would then be seen as embryonic nurses rather than skivvies.”

“There is remarkable resistance to letting people through the various ‘glass ceilings’ and allowing them to move from care assistant to nurse, and from nurse to manager.”

“Care assistants should not be seen as short-term employees doing dirty work for little money and no emotional and ‘respect’ reward, but people who may go into nursing eventually or who may choose to remain as care assistants, at the top of that particular tree, with all its attendant qualifications and respect.”

Recommendations

- Staff should be encouraged to identify residents with new problems or for whom there is concern, and to refer to the next most senior person; also to ask questions and to question the suitability of care. In other words staff should do

their best for residents - as they would do for their own relatives.

- There should be a career pathway for each member of staff - from certificates of accomplishment (not attendance!), a little extra pay (cf. mental health services), to SVQ's and progression towards a nursing career.
- Staff should be given additional responsibilities, such as
 - writing in case notes
 - providing continuing simple interventions / rehabilitations under the direction of a physiotherapist, speech & language therapist, complementary therapist or arts therapist
 - creating a commendation book
- Improvement in rates of pay for care assistants
- Greater exposure to learning opportunities – particularly in the workplace
- Induction of Care Homes (Nursing) in notational training programmes for nurses and possibly in training programmes for care assistants

Reference

The Moral State We're In – *A Manifesto for a 21st Century Society* by Julia Neuberger (2005) - chapter one, 'The Elderly'. Short version.

Annex 4

AHPs Support to Patients in Long-Term Care Report of Working Group, 2002

- Residents need continuing (weekly) assessment – not 6 monthly. All staff need to think imaginatively about what can be done for each resident.
- Staff need to be aware of services and other sources of help and how to make referrals.
- Continued provision of community support services.
- The nutrition of elderly people and nutritional aspects of their care in long-term settings.
- No formal evaluation of the impact of training on actual practice.
- Staff require further 1:1 advice on the needs of individual residents.
- No generic community OT or SLT service.
- The clinical skills of the AHP training team are not fully utilised.

Greater Glasgow NHS: Report of Health Support to Homes Working Group, 2004

- Explore the potential for the AHP Homes Training Team to provide an intervention-based model.
- Development of a rehabilitation model within care homes to continue through progress in developing the AHP training team.
- Development of palliative end of life care to enable people to stay in their care home appropriately at the end of life: through provision of specialist support, education and training in all care homes.

Voices from the Independent Sector: Nurses Working in Care Homes in Scotland

Quality of Care

- There was a strong desire to reduce paperwork and bureaucracy. Statutory agencies should undertake a review of the level of paperwork and bureaucracy being required of Care Homes .
- An evidence based skill mix review should be conducted in the Care Home sector to identify the optimum skill mix required to ensure best quality outcomes for residents which recognises the changing roles of nurses and carers

Training and Development

- Care Home nurses should have access to the support of an older people's specialist nurse or nurse consultant
- Professional nursing leadership is critical to the future development of care for older people in Care Homes and Care Home nurses should therefore have access to clinical leadership training.
- All staff groups should have equal access to career development opportunities in order to maximise the skill base of nurses working with older people in care homes.

Extracts from Voices from the Independent Sector: Nurses Working in Care Homes in Scotland published by Royal College of Nursing Scotland. RCN Scotland 2005

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