MY HOME LIFE

RESEARCH BRIEFING 7: 2016

Our vision is a world where all care homes are great places to live, die, visit and work.

Developing the workforce

This updated research briefing paper was written by Julienne Meyer and based on a review of the literature on quality of life in care homes, undertaken by the National Care Research and Development Forum in 2006[1] , which was later updated by a review of reviews (2006-2016), undertaken by the My Home Life team. My Home Life is an international programme of work aimed at promoting the quality of life for those who are living, dying, visiting, or working in care homes for older people.

- Overall, research on developing the workforce seems to reflect many of the findings of the original review (NCHRD, 2007). Post 2007, new evidence suggests:
- Evidence on training to improve staff members' communication skills (Eggenberger et al., 2013; Vasse et al., 2010; Spector et al., 2013; McGilton et al., 2009).
- Studies looking at factors that affect recruitment, retention and burnout for staff (Westermann et al., 2014; Chenoweth et al., 2010; Jeon et al., 2010).
- Studies on staff making a positive difference (Donald et al., 2013; Levy-Storms 2008)
- Studies on abuse and restraint (Ayalon et al., 2016; Moehler et al., 2012).
- Studies looking at the impact of teaching physical skills (Weening-Verbree, 2013; Taylor et al., 2011).
- Studies suggesting that staff training is not evidence based (Fossey et al., 2014).

Introduction

There is a lack of reliable information about the size and structure of the independent carehome workforce (Eborall 2005). Estimates suggest 72,000 employed by the local authority and 390,000 in the independent sector (private and voluntary). Of the 390,000 staff (including support staff) working in the independent sector an estimated 47,000 are managers and supervisors, 288,000 are care workers and 36,000 are registered nurses (Eborall 2005).

The workforce is predominately female, part-time is common and settings for older people tend to employ older workers (Eborall 2005).

There is evidence that training enhances competence, self-confidence, job satisfaction, morale and teamwork, but low status, low pay and low ratio of qualified to non-qualified staff, restricting opportunities for passing on skills, are key factors likely to influence care standards (Eyers 2003). Little is currently known about the education and training received by staff in care homes.

Improving workforce skills

The changing nature of the workforce in care homes needs to be closely scrutinised (Spilbury and Meyer 2004; Bridges 2004). Modernising the Social Care Workforce (TOPSS 2000) was the first comprehensive national training strategy to analyse the skill needs of

[1]NCHR&D Forum (2007) My Home Life: Quality of *life in care homes – Literature review, London: Help the Aged.*

people working in the social care sector in England. The strategy proposed an action plan to improve both the qualification base and the quality of training. Key themes included: improving workforce planning; modernising quality assurance of training outcomes; roles and responsibilities; and partnership (TOPSS 2000).

It is recognised that to ensure the ambition of dignity in care, joined-up care, and healthy ageing it is vital that the workforce is skilled, dedicated, valued and supported to do its best (Philp 2006). Challenges, including a limited pool of workers, the highly gendered workforce, the care responsibilities of the care workforce, and ethnicity, indicate that a strategic approach is required (Philp 2006; Scottish Executive 2006).

There is no doubt that over time the role for care home staff has changed considerably and their level of skill has not kept up with the changing health and social needs of their residents. The emphasis on 'care at home' and 'care in the community' has led to residents admitted to care homes being more frail (physically and mentally) at the later stages of life, often with multiple medical needs and having higher dependency levels. In addition, pressure on acute beds also led to an interest in care homes developing intermediate care services, requiring staff to develop new roles and re-skill through education and training.

Trends towards integration of health and social care and blurring of roles across the interface of primary and secondary care also led to a renewed interest in the care home sector. Further, the National Minimum Standards for Care Homes for Older People put the spotlight on the education needs of care home staff. More recently, government-funded initiatives, such as non-cancer palliative care in the community, have led to NHS staff working much more closely with private care home staff to raise overall standards, in the example with regard to end-of-life care.

Leadership and management

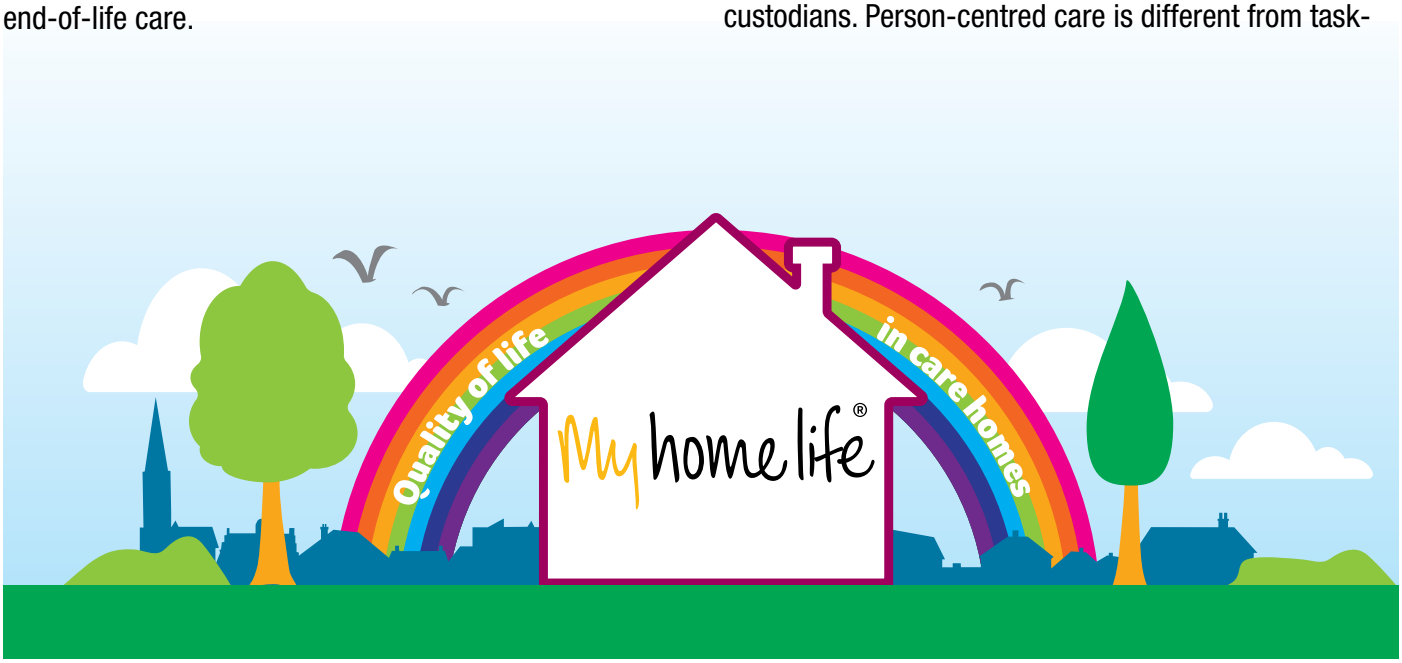
There is a strong body of evidence to support the strengthening of the management and leadership skills in care homes. Research suggests that well-run care homes depend crucially on the skills and leadership attributes of the managers (Moiden, 2002). Their role often combines that of lead clinician, operational manager, finance manager, marketing director, and advocate for residents and staff (Chambers and Tyrer, 2002).

Positive staff experiences of a manager's leadership are critical to ensure job satisfaction and workforce retention, the provision of quality care and the wellbeing of care recipients, and potentially a reduction in associated costs (Jeon et al., 2010). Jeon and colleagues (2010) suggest from their review findings that the essential attributes of good leadership for aged middle management are hands-on accessibility and professional expertise in nurturing respect, recognition and team building, along with effective communication and flexibility. They add that successful leadership and management outcomes depend on coherent and good organisational leadership.

My Home Life recommends that a national, funded development programme is needed to produce a group of competent care home managers and proposes that development activity in care homes should not be isolated from the rest of health and social care services (Chambers and Tyrer, 2002).

Supporting the emotional development of care staff

In addition to training, other forms of support may also be needed. The role of care home staff has become more demanding and complex, particularly if they are working therapeutically rather than simply acting as custodians. Person-centred care is different from task-



orientated care, which can itself be seen as an individual and organisational psychological defence mechanism against anxiety (Hurtley 2003; Menzies 1997). Person-centred care puts greater emphasis on emotional care, which is particularly needed for those working with people who have dementia, and allows connection, involvement and the promotion of emotional well-being (Hurtley 2003). Some evidence suggests that nursing aides can improve their therapeutic communication during care. For this, they not only need more training in therapeutic communication but also ongoing, dedicated supervision in psychosocial aspects of care (Levy-Storms 2008). Providing space for reflection and recognition offers staff ways of dealing with the difficulties they encounter (Hurtley 2003). Care staff can improve their communication with residents with dementia when strategies are embedded in daily care activities or interventions are single-task sessions at set times (Vasse et al., 2010). In one example of help given by practitioners a local chaplain supported staff through the more emotional aspects of the work.

Good environment for learning

Relationship-centred care provides not only a means for delivering quality of life for frail older people, but also for engaging positively with relatives and for supporting staff, both as workers and learners (Tresloni and Pew-Fetzer Taskforce 1994). Research suggests that enriched environments for learning achieve a sense of security, continuity, belonging, purpose, fulfilment and significance (Nolan et al., 2001). Managers play a key role in creating this environment. Learning is also important for older people. Research suggests that engagement with learning and similar activities enhances quality of life, lessens dependency and improves wellbeing (Withnall and Thompson 2003). However, learning communities in care homes are underdeveloped and it is suggested that quality-monitoring systems should prominently feature intellectual stimulation. It is suggested that active and engaged residents might bring savings in medical and care costs (Soulsby 2000).

A care home workforce fit for the future

In order to ensure that the country has a care home workforce fit for purpose in the future, research needs to track the education and training needs of staff and to share lessons learned from attempts to improve practice through education.

Successful creative learning initiatives need to be strategically developed and supported to become part of mainstream practice. Education and training need to be relationship-centred and concerned about ensuring that the whole workforce learns together at its place of work as part of an initiative to improve quality, rather than sending individuals on external courses designed to deliver a qualification and geared to specific of work.

Reducing the use of physical restraint and teaching physical skills

There is insufficient evidence supporting the effectiveness of educational interventions targeting nursing staff for preventing or reducing the use of physical restraints in older adult long-term care (Moehler et al., 2012). The most effective place to intervene at the present time is by directly targeting physical restraint in long-term paid carers (Ayalon et al., 2016).

Strategies to improve oral health in the older population mainly focus on knowledge, self-efficacy and facilitation of behaviour. Although all strategies have a statistically significant positive effect on knowledge and health benefits of the care providers they do not show a significant effect on positive oral health (Weening-Verbree 2013). In regards to moving and handling training, evidence demonstrated an improvement of resident mobility and transfer abilities (Taylor et al., 2011).

Student nurse placements and retaining nursing staff

The potential of care homes to provide good learning environments for staff and students must be recognised and, in order to develop knowledge and skills among

staff, there need to be closer working links between local communities, institutes for higher education and the care home sector (Davies et al., 2002).

Practice placement appears to have had a positive effect on student learning and the subsequent desire of students to work with older people, compared with their classroom teaching (Brown 2006; Nolan et al., 2002). However, creating an enriched environment requires sufficient resources, solid leadership, continuity of staff, self-awareness and a passion for gerontological nursing to engender excitement and enthusiasm (Brown 2006). Through encouraging increased financial investment, teaching care homes are an ideal for which to strive.

Chenoweth et al., (2010) conducted a systematic review of what factors attract and retain nurses in aged and dementia care. They found helpful strategies were: careful selection of student nurse clinical placements and their ongoing supervision and education, training for skills, leadership and teamwork for new and existing nurses, increased staffing levels, pay parity across different health settings and family friendly policies. A family friendly, learning environment that values and nurtures its staff, in the same way as nurses as expected to value and care for their patients and residents, is critical in ensuring their retention in dementia and aged setting (Chenoweth et al., 2010).

Better training means improved quality of life

The care home sector tends to employ part-time and untrained care assistants. While the great majority provide humane and empathetic care, the lack of training results in technical, attitudinal and coping deficiencies (Henwood 2001). The potential benefits of training in long-term care setting for both staff and residents were indicated by studies showing that after training, staff report increased competence, greater self-confidence, enhanced job satisfaction and morale and better teamwork (Nolan and Keady 1996). Other evidence shows that training helps to reduce injury among staff, minimise sickness and absenteeism and improve recruitment and retention. Several tangible benefits are also apparent for residents, such as less use of sedation and restraint, more individualised care, and enhanced interactions between staff and residents (Nolan and Keady 1996). Eggenberger et al.,'s (2013) review demonstrated that communication skills training in dementia care significantly improved the quality of life and wellbeing of the person with dementia. Communication skills training also showed significant improvement of professional and family caregiver's communication skills, competence and knowledge. Training was additionally found to impact on the way staff behaved towards residents (Spector et al., 2013; McGilton et al., 2009).

There is also other evidence of benefits to training including improved knowledge, assurance that care provision will be effective, improved practice and higher-quality care, and encouragement of problem-solving, reflection and motivation (Clelland et al., 2005; Birnie et al., 2003; Kenny, 2002; Deaken and Littley, 2001; Robertson et al., 1999).

Training needs to be embedded in a coherent programme of staff development and support (Nolan and Keady, 1996). There is also evidence to suggest that training is most effective if combined with follow-up supervision 'on the job'. Furthermore, several studies have shown that regular supervision increases creativity and personal assessment of patients' potential rehabilitation improves co-operation with colleagues and increases self-confidence (Brocklehurst, 1997).

Learning as part of the care culture

Staff must recognise the need for training, believe that it will result in change, and see benefits for themselves. This is more likely if training is related to an indentified need, involves staff in design, content and delivery of the programme, and is valued by management (Nolan and Keady 1996).

A number of creative learning initiatives have been developed for care homes, which are designed to be delivered either in the workplace or as part of a community development initiative. They range from

implementation of small-scale teaching packages on single topics to comprehensive educational programmes designed for all levels of staff working in a care home, in order to improve overall quality of care (Meyer et al., 2006; Wild et al., 2005; Meehan 2004). Central to the premise of learning is the need for residents, relatives and staff to share their experiences of quality in care homes when living and working together.

The review of the literature reviews (2007-2017) suggests that more research is required to explore the effect of staff training in communication and how this may improve quality of life for people living with dementia (Eggenberger et al., 2013; Vasse et al., 2010). Research from the review of the literature reviews has also demonstrated the leadership and teamwork are important components for staff retention and wellbeing (Jeon et al., 2010; Chenoweth et al., 2010).

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