

Teaching Care Homes: The centres of excellence for care, training and practice development.

Foreword by Professor Martin Green OBE, Chief Executive Care England, DH: Independent Sector Dementia Champion

In the past 30 years we have seen a tremendous change in the population of care homes and they have developed from being a lifestyle choice, to the place where people who have multiple health conditions live because they need constant support. The people who live in care homes today, usually have at least four serious long-term conditions, and a large percentage of them are living with some form of dementia.

The change in the care home population, and the increased complexity of residents, has gone largely unnoticed by the rest of the system, and the enhanced skills and competencies of the care home staff, have not received proper recognition. In many areas, such as dementia, and end of life care, the care home is a centre of excellence with so much expertise and knowledge that could be so valuable to other parts of the health and social care system.

In not recognising the skills and experience of care home staff, the system is ignoring a fount of knowledge that could inform best practice and improve care in all settings.

The Teaching Care Homes pilot was set up to ensure that people who are training to be the next generation of health and social care professionals, could learn from the experience of the care home sector, and would be better equipped to manage the health complexities and social care needs of an ageing population. The pilot was also set up to ensure that the staff in care homes had the confidence and time to be centres of learning, as well as care.

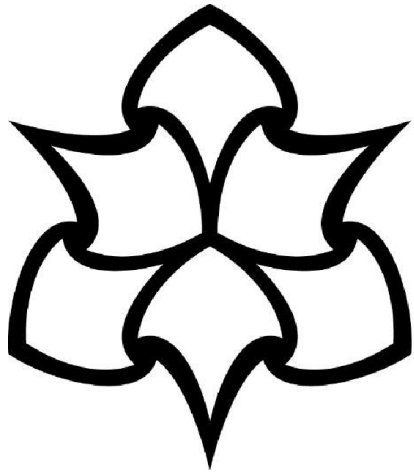
Thanks to the commitment, professionalism, and passion of the people working in care homes that were part of this pilot, we have seen the benefits of the care home as a centre of training and practice development. Integration will only happen when all bits of the system work together and share their knowledge across all services.

I want to pay tribute to all those who were involved in this work, especially to the Managers and Staff of all those care homes who took part. I also want to thank the Chief Executives of the participating organisations, for the leadership they showed in supporting their services to enter this initiative.

The Teaching Care Homes Pilot was a collaborative project, and I want to offer my thanks to our partners at the Foundation of Nursing Studies, Manchester Metropolitan University, and the International Longevity Centre, who have all worked tirelessly to ensure that this pilot programme was a success.

I am particularly grateful to Professor Deborah Sturdy who initiated the idea and has led and developed the programme throughout the pilot phase. Without Deborah's vision, energy and commitment this pilot would not have been possible.

The first stage of the Teaching Care Homes Pilot has been a resounding success, and our challenge for the future is to mainstream this work and to ensure that the whole system benefits from the expertise and knowledge of the professionals working in the care home sector.



**Manchester
Metropolitan
University**

THE EDUCATION AND DEVELOPMENT
OF NURSING STAFF IN CARE HOMES

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Introduction

This work forms part of a wider project being commissioned by Care England, on the recruitment, retention and professional development of care home nurses. Our role in this project is to explore the factors which support high quality education in care homes, understanding the personal and professional development required but also the conditions under which education thrives in this area. We aim to develop a coherent framework, which can be used to support educational development in care homes, acknowledging not only the science but the art of nursing practice. It is hoped that this framework can be used as a model of best practice for education and development in the care home setting.

Background

The concept of the Teaching Care Home (TCH) was established in the 1960's, gaining momentum in the 1980's through the work of Butler (1981). Described as 'Teaching Nursing Homes', they were proposed as a way to deal with the lack of research and training into the care of the elderly in the United States at that time. Butler (1981) described some important features of the Teaching Nursing Home model as follows:

- Affiliation with universities
- Development of a research base for improving care
- Education and training for professionals in the speciality of older persons care
- Develop diagnostic techniques and assessment specifically for older people

Viewed as offering opportunities for research into the ageing process and disease prevention, they were to be aligned with universities, specifically medicine, nursing and social care programmes. The increased costs of running such ventures were to be viewed in the context of the potential reduction in expenditure related to inappropriate admissions and their role in improving quality of care for residents (Schneider, 1983). Considering quality, a US study suggests that there are multiple improvements to care found in TCH's when compared to Comparator Nursing Home sites (CNH). Shaughnessy et al (1995: 8) states:

'In TNHs patients were less likely to experience functional decline and were less likely to be catheterized, restrained or heavily sedated... The differences in hospitalisation, patient status outcomes and care patterns occurring in combination indicate that a different care environment existed in TNHs'

Chilvers & Jones (1997) suggest the concept of the TCH could offer value to nurse education in Great Britain in terms of knowledge development and research, although this would require adequate preparation of staff and links to be made with higher education providers. Currently, student nurses can access care home placements during their undergraduate education but this is not usually through the formal TCH model. Care home work is viewed by nurses as unattractive and of low status and this can be due to experiences during pre-registration nurse education and socialization (Henderson, 2008). The desire to work with older people is shown to decrease over the duration of undergraduate nursing programmes (Stevens, 2011) and this has implications for choice of nursing career upon qualification. Provision of effective clinical placements for students in care homes can be challenging. Lack of staff, student resources and the financial problems suffered by many homes can impact on provision (Storey & Adams, 2002). Strategies to engage

care home staff more effectively with universities have been suggested. These include study days, which can be offered to care home staff through reciprocal arrangements and the provision of designated link teachers (Davies et al, 2002).

On qualifying, care home nursing is seen as a low priority career choice for registered nurses, an area perceived as one with little innovation, development or professional opportunity. Care home nurses have less access to educational opportunities when compared to their NHS colleagues and a large amount of staff working in care homes are from overseas. This creates educational challenges related to support, supervision, CPD and retention (Spilsbury et al, 2015).

Overarching Aim

To explore the concept of effective education in care homes. What knowledge is required to work in this environment and under what conditions do learning and development thrive?

Objectives

1. To scope the current evidence relating to the education and development of all nursing staff in care homes
2. To assess and analyse the current issues relating to education in the five identified care homes using an appreciative inquiry approach
3. To develop a framework outlining the factors relating to effective education in care

Scoping Review

Introduction

The first stage of this study was to assess the state of current educational provision and development for nursing staff working in care homes in the United Kingdom (UK). This important information acts as a baseline to provide context to Stage Two (Appreciative Inquiry) and ultimately the work can be used to support thinking at Stage Three (Educational Framework Development).

A scoping review method was chosen as this provides access to a broad range of information utilizing a flexible and iterative approach. The focus is not to assess the quality of the located studies, but to provide a wide ranging picture of what is currently happening in care homes from an educational perspective.

Background

There are currently 426,000 older and disabled people in residential care homes (including nursing), and of these, approximately 405,000 are aged over 65 (LaingBuisson, 2014). As the ageing population increases, the requirement for high quality care provision in care homes is set to rise, although multiple concerns have been identified which lead to inconsistencies in care provision. In a survey conducted by the RCN (2012) problems identified include; residents rising level of care requirements, inappropriate admissions to care homes, poor nursing skill mix and inadequate staffing levels.

Specifically, concerns related to nurse education and training included:

- The lack of funding to provide education for nursing staff above essential mandatory training
- The lack of training for care assistants (who provide a lot of the care delivery in care homes)
- Care homes are left understaffed when staff attend training and some staff attend on their days off, in their own time
- The high turnover of staff leads to training having to be repeated
- Training is often focused on the need to fulfil Care Quality Commission (CQC) requirements, rather than an ongoing commitment to nursing workforce development
- The fear that training will be compromised due to reduced fees for residents from local authorities

For qualified nurses, working in care homes is viewed as unattractive and of low status and this might be due to their pre-registration education and socialization (Henderson, 2008). Stevens (2011) assessed career preferences and associated rationale for these in a longitudinal study of undergraduate nurses in Australia. The findings suggest that the desire to work with older people decreased over the duration of the course. By the end of the programme, the 'high tech' areas such as intensive care and surgery were ranked highly compared to the 'low tech' areas such as working with older people and those with mental health problems. However, it is in these 'low tech' areas that nurses are most able to use their nursing skills and as Stevens (2011: 949) states, '...cement its status as a true profession'. Care home work is challenging and autonomous. Residents are frail and vulnerable and need specialized care. However, many nurses choose this work to fit around other commitments, rather than viewing it as a viable career pathway (Spilsbury et al,

2015). The lack of developmental opportunities for nurses working in care homes, the poor perception of work with older people and the view that care home work is convenient rather than exciting is of concern and worthy of further exploration.

Further, all of these factors are important when considering education and development in care homes and provide context to the scoping review.

The aim of this scoping review was to explore the evidence relating to the education and development of nursing staff in care homes in the United Kingdom (UK). For the purposes of this review the term 'nursing staff' includes registered nurses, support worker and managers working in care homes in the UK. Findings will be summarised and presented in order to provide an overview of current research and significant information from the studies will be described. While there are known to be multiple approaches to the delivery of education in care homes there seems to be little consensus about the most effective and coherent way to facilitate ongoing development for staff. Understanding what works well is important when considering the development of a framework which will be used to support effective education in the future. The purpose of this review was to explore a comprehensive amount of literature and gain an overview of the current provision. We wanted to identify areas of innovative practice which might be replicated by others, such as care home practitioners and policy developers but also locate the barriers to educational provision. In doing this the review supports the next stage of this work.

Method

For the purposes of this review we drew on the framework suggested by Arksey & O'Malley (2005), later refined by Levac et al (2010) to enhance scoping review methodology (Table 1). Due to the exploratory nature of this work, a scoping review

method was identified as the most suitable way of accessing multiple studies utilizing different designs and methods. Arksey & O'Malley (2005) suggest an iterative and reflexive process whereby researchers do not adhere to strict search terms or study criteria. By adopting this approach we were open to accessing all relevant literature which might not have been identified had stringent terms been applied from the outset. However, a systematic approach was utilized during the identification, data extraction and evaluation of the included studies.

Scoping Review Methodological Framework (Arksey & O'Malley, 2005)

Stage	Description
1. Identify the research question	Questions can be broad in nature in order to capture a range of studies. If large amounts of data are located, parameters can be applied later.
2. Identify relevant studies	This stage includes plans about where to search, search terms, sources, time span and language. Time and resources constraints might limit searching. Sources might include electronic databases, reference lists and hand searching.
3. Study selection	This is an iterative process based on the research question set and on ongoing understanding of the subject through reading the studies found
4. Chart the data	This is used to extract the data from the studies found.
5. Collate, summarise and report the results	This stage is used to present a broad overview of the studies although should not be a synthesis. Following this, the data is presented in themes in a clear and consistent manner
6. Consultation (optional)	This stage provides opportunities for stakeholder involvement which can be helpful in terms of providing additional

comments and insights beyond those
found in the studies

Each of the stages will be discussed in the context of our own study and the ways in which the framework supported our decision making will be analysed.

The research question

Arksey and O'Malley (2005) suggest adopting a broad approach in order to generate good breadth of coverage although large numbers of references might be found in this way. However, once a sense of the volume of references is gained, parameters can be applied. Therefore our initial research 'question' was 'What is known from the existing literature about educational provision to support nursing staff in care homes with their ongoing development?' We appreciate that placing a focus on 'educational provision' meant that some important studies might be excluded although there was a need to contain the review process and pragmatic decisions needed to be made. For example, when exploring relational aspects of nursing care, such as compassionate practice, studies tend to focus on 'encouraging' and 'supporting' skills in these areas, rather than discussing 'education' per se. This opens up questions about whether or not staff can be 'educated' to deliver compassionate care, or whether it is the culture and leadership of an environment which enables these softer skills to flourish. We envisage that these questions will be explored during the next stage of the research, during data collection, when further important literature can be used to support the discussion.

Identify relevant studies

A strength of scoping studies is that they can capture a comprehensive range of evidence. Levac et al (2010) suggest a team approach in order to provide context to inform the scope of the study. Limiting the scope of studies might be unavoidable although this should be stated in the study limitations. For practical purposes decisions have to be made about practical issues such as dates of searching and language (Arksey & O'Malley, 2005). For the purposes of this review decisions had to be made in terms of time spent on the scoping of *existing* research on the current educational opportunities in care homes, against time spent on the Appreciative Inquiry research; the development of *new* thinking about what works well. Systematic searches of the literature were performed during May and June 2016 using the databases MEDLINE, CINAHL, ERIC and Scopus. The search strategy was developed jointly with our head health librarian at MMU and initially identified multiple search terms which had to be refined, reflecting time and budget constraints. In order to achieve our aim which was to gain an overview of the subject, we used the search terms 'care homes', 'nursing staff', 'education', 'learning', 'staff development', and 'professional development' to identify relevant studies. Due to practical reasons we limited the publications to peer reviewed studies written in English and undertaken in the United Kingdom (UK) between May 2006 and June 2016, acknowledging that some interesting studies might have been excluded (as discussed when refining the question). We included studies which described the following information; purpose, design, sample, intervention and important results although some studies did not report all aspects and decisions were made by the review team in terms of which studies were included.

Study Selection

An initial inspection of the studies revealed many that were irrelevant to our question. A large number of citations were revealed to be opinion pieces, for example, views about the need for further education for care home staff rather than actual research studies on how this might be achieved. Many of the studies were educational audits and learning assessments and due to the paucity of 'higher quality' studies found, we decided to include these studies in the review. The articles were reviewed by two reviewers to agree on the final studies to be considered. If abstracts were ambiguous, full text articles were requested. On review of the studies, some secondary references were followed up and added to the review.

Presented below is a summary of the information retrieved to inform this scoping review. The majority of the located studies have a medical focus with a lesser amount of studies relating to general education and mentoring. Initial scoping retrieved citations relating to dignity, emotional caring and sexuality. However on closer reading, these were found to be opinion pieces or irrelevant to the research question. A total of 34 studies were selected for inclusion in the review.

Scoping Review Outcomes

Focus of study	Number of studies included in final review
Dementia	7
End of Life Care	10
General Education and Mentoring	4
Chronic Disease/ongoing conditions	3
Continence	1
Skin and Wound Management	3
Falls	3
Delirium	2

Charting the Data

Data was extracted and recorded using an adapted version of the framework suggested by Gonzalez & Kirkevold (2013):

1. Author/Year
2. Purpose (what was the reason for undertaking the study?)
3. Design of the study
4. Sample (e.g. care home nurse, care home manager)
5. Intervention (e.g. implementation of a training/education programme)
6. Outcome/Main findings

These headings were used for two reasons. First, they facilitated the description of data most important to our study as a whole. Second, the extraction table can be used as a standalone resource to provide readers with an accessible and coherent overview of the style and findings of the studies included. Even though a uniform approach was taken, in places some information was not presented, a problem highlighted by Arksey & O'Malley (2005). Therefore the table has some gaps.

Collate, summarise and report the results

In comparison to a systematic review, a scoping review does not attempt to comment on the strength of the evidence found. The focus of a scoping review is to present an account of the literature in a narrative style. In this way, the reader is provided with an overview of the studies, although it is still important to present the findings coherently. Levac et al (2010) recommend three stages to this process:

1. Analysing the data
2. Reporting results
3. Applying meaning to the results

Levac et al (2010) go on to suggest that the meaning and implications of the scoping results should be considered. Indeed the rationale for undertaking this review was to provide initial understanding about the current state of educational arrangements in care homes in the UK. Therefore it can be considered as a baseline for our ongoing research study although it does provide important information as a standalone piece of work which might be helpful to others.

Consultation

Described as an optional stage by Arksey & O'Malley (2005: 29) they continue by endorsing the requirement to consult with others during review development.

Advantages to this approach might include the suggestion of additional studies along with 'valuable insights' about factors the researchers might not be aware of. For the purposes of this review we consulted with practitioners and stakeholders in order to gain a range of views which we hoped would be beneficial to the process.

Results

The results will be presented thematically in relation to the focus of the educational intervention which in most cases was linked to a clinical issue. Four studies were located which discussed education and mentoring issues generally, and these studies will be discussed separately. Table 3 presents an overview of the extracted information from the articles included in this review.

Author/Year	Purpose	Design	Sample	Intervention	Important Results
Chronic Disease Management					
1. Heeley-Creed et al (2007)	To improve diabetes care in 2 residential homes	Pre/post intervention evaluation	Qualified nurses and support workers	Implementation of a Diabetes Training Programme	<ol style="list-style-type: none"> 1. On-site tailored training raises awareness of diabetes and contributes to improved diabetes care 2. Pre-course information results in improved attendances 3. Supplying files of practical information for use after the training has finished is helpful
2. Shepherd et al (2008)	To improve knowledge and care of diabetes	Pre/post intervention evaluation	484 staff in 115 care homes Support workers, Qualified staff, Managers and Cooks	Implementation of the PPDE Pan Peninsula Diabetes Education Initiative	<ol style="list-style-type: none"> 1. Raised awareness of diabetes 2. Foot care pathway developed 3. Increased knowledge and skills of care home staff 4. Rolling education programme needed due to high turnover of staff
3. Smith et al (2008)	To assess the educational priorities relating to stroke care	Questionnaire survey	115 qualified and 19 care assistants	Survey to assess educational needs	<ol style="list-style-type: none"> 1. Care home staff need and want more stroke education 2. Stroke education should be to the benefit of residents 3. Guidelines on stroke care should be developed 4. Lack of knowledge of training opportunities, lack of employer encouragement and staff shortages are all prohibitive factors

Author/Year/Location	Purpose	Design	Sample	Intervention	Important Results
Continence Education					
4. Rodriguez et al (2006)	To assess continence prevalence, knowledge and care	Survey	186 care homes	N/A	<ol style="list-style-type: none"> 1. Knowledge/practice gap identified 2. The belief that incontinence is because of old age suggests a need for more training and education 3. Working in partnership with other services should underpin practice

Author/Year	Purpose	Design	Sample	Intervention	Important Results
Delirium Education					
5. Featherstone et al (2010)	'Stop delirium!' educational package	Interviews and questionnaires used to assess change in staff knowledge	9 units from 6 care homes	Full time delirium practitioner working with staff over 10 month period	<ol style="list-style-type: none"> 1. Manager support important for it to be successful 2. Flexibility re length and timing of sessions reduced the effect on staffing levels 3. Interactive education works well 4. Staff ownership of tools and materials produced makes them more powerful in practice 5. Sharing of resources across the six care homes made work more valuable 6. Use of case studies as learning activities was helpful
6. Siddiqi et al (2011)	'Stop delirium' (main report)	"	"	"	<ol style="list-style-type: none"> 1. Reduction in number of falls and prescribed medications 2. (see above)

3. Increase in self reported confidence in delirium care
4. Helpful for training to be in the afternoon
5. Some staff very enthusiastic - ? helpful to train 'champions'

Author/Year	Purpose	Design	Sample	Intervention	Important Results
Dementia Education					
7. Board et al (2012)	To acquire knowledge and skills about dementia	Evaluation of an educational intervention	20 staff (mixed cohort) working at three of the groups care homes (Colten Care)	Dementia education programme 1 day a week for 5 weeks	<ol style="list-style-type: none"> 1. Liked informal and interactive nature of sessions 2. Hearing views of carers was well evaluated 3. Resulted in 2 and a half day educational package (endorsed by Bournemouth University)
8. Brown Wilson et al (2013)	Development and delivery of a training programme	Mixed methods	11 staff (mixed)	8 workshops on the principles of relationship centred care	<ol style="list-style-type: none"> 1. Education through facilitated workshops is helpful to care delivery 2. Effective way to support practice change
9. Elliot et al (2014)	Delivery of distress reaction training	Evaluation	Mixed cohort	Distress reaction training 3 hour sessions by My Home Life Admiral Nurses	<ol style="list-style-type: none"> 1. Focused interactive training is valued by care teams
10. Hughes et al (2008)	To explore knowledge and confidence of staff dealing	Questionnaire	254 care staff	N/A	<ol style="list-style-type: none"> 1. Need for appropriate training. Positive link between education preparation and quality of care

					with people with dementia	<ol style="list-style-type: none"> 2. Variety of ways in which staff can receive training 3. Setting in which staff receive training is important 4. Importance of an environment which promotes on the job training 5. Culture of the home is very important
11. Khan & Curtice (2011)	Particular focus on the issue of antipsychotic medication use and non-pharmacological approaches in managing behavioural and psychological symptoms of dementia (BPSD).	Pilot project	4 care homes	Dementia in reach service delivered by CMHT		<ol style="list-style-type: none"> 1. Cohesive, ongoing and extensive education and training of care home staff is needed 2. Care home managers expressed the need for dementia training 3. Improvements in knowledge and confidence noted at end of CHIP (Care Home in reach Programme)
12. Livingston et al (2012)	To explore barriers and facilitators to delivery of end of life care to	Qualitative interviews	58 staff across the range	N/A		<ol style="list-style-type: none"> 1. Staff require education and support relating to discussion and implementation of plans around end of life care in dementia

	people with dementia				<ol style="list-style-type: none"> 2. Education needs to include communication in terms of dementia death 3. Staff need to know about religious and cultural practices
13. Velszke (2014)	Evaluation of the Dementia Services Development Centre's Best Practice in Dementia Care Learning Programme	Evaluation (qualitative and quantitative)	100 feedback questionnaires, 60 reflective exercises and 89 online responses to a service manager survey	6 month period of BP training supported by a BP trained facilitator	<ol style="list-style-type: none"> 1. Increased awareness and understanding of dementia 2. Increased use of evidence based care 3. Wider use of interventions following the course 4. More effective interactions between staff, carers and people with dementia

Author/Year	Purpose	Design	Sample	Intervention	Important Results
Education and Mentoring (General)					
14. Allan (2010)	To explore the mentorship of overseas nurses (part of REOH study - Researching equal opportunities for overseas nurses and other healthcare		<p style="text-align: center;">w o r k s)</p> Ethnographic interpretive study	93 overseas- trained nurses 24 national and 13 local managers and mentors across 6 research sites including care homes	

N/A

1. Overseas nurses are treated unfairly during supervised practice and experience discrimination
2. Problems sure to lack of

3. Improvement in practice

4. Mentor programme level need to value OS nurses and their training, and also their future training needs

15. Banning & Hill (2006)	To explore the use of nursing homes as practice placements for pre-registration students	Illuminative evaluation questionnaire	9 nursing homes 10 students	N/A	<ul style="list-style-type: none"> 5. Confusing for mentors – OS nurses treated as a pre-registration student but also left to get on with the work 1. Students felt like they would be learning less than if in an acute hospital setting 2. Did not recognize the specialist skill required to nurse older people 3. Recognized friendly and supportive culture of nursing homes 4. Mentors/staff need to maximize learning potential in homes
16. Lees et al (2006)	To explore training needs of registered nurses and carers	Training needs audit	10 private nursing homes	N/A	<ul style="list-style-type: none"> 1. Three key areas of training need – falls, diabetes and confusion 2. Informal sessions, delivered by non-academic staff in the nursing home itself 3. Ongoing support mechanisms required for nursing staff working in isolation in homes
17. Rout et al (2010)	What are the influences on learning and development in nursing and residential homes	Interviews	HCA's and assistant practitioners needs. Interviews with a range of staff including	N/A	<ul style="list-style-type: none"> 1. Flexible learning, progression routes, IT support, manager engagement and evaluation of courses required <p>managers</p>

2. Study skills education required
3. Needed to demonstrate the value of learning to staff
4. Lifelong learning network?

Author/Year	Purpose	Design	Sample	Intervention	Important Results
Falls Education					
18. Borland et al (2012)	To explore understanding of suitable footwear for older people in care homes	Exploratory descriptive survey	20 RN's in 6 care homes	N/A	<ol style="list-style-type: none"> 1. Improved safe footwear education needed for staff 2. Guidelines aimed at educators (to inform students) about suitable footwear might be helpful and might reduce falls
19. Cox et al (2008)	RCT exploring education of nursing home staff and link to fracture prevention	RCT	209 care homes	Educational programme delivered by specialist osteoporosis nurses	<ol style="list-style-type: none"> 1. Structured training leads to increase in prescription of treatments, which in turn can prevent fractures 2. the intervention significantly increased the prescription of bisphosphonates and calcium/vitamin D, but was not associated with a significant effect on the rate of falls or fractures
20. Mitchell & Lawes (2007)	An audit of learning related to falls prevention	Audit	19 audits across 2 PCT's	3 learning routes facilitated by Falls Champion: <ol style="list-style-type: none"> 1. E-learning 2. Independent Manual 3. Group sessions 	<ol style="list-style-type: none"> 1. Education required to decrease likelihood of falls 2. Falls education required 3. Need to consider individual learning styles 4. Audits can help with implementation of NICE guidance

Author/Year	Purpose	Design	Sample	Intervention	Important Results
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Oral Care Education

21. Durgude and Cocks (2011)	To assess knowledge of oral hygiene and reported practice of oral care for patients with dysphagia	Questionnaire	53 RN's across 6 nursing homes	N/A	<ol style="list-style-type: none"> 1. RNs need more training which includes information about medical conditions associated with poor oral hygiene, oral health, drugs that impact upon oral health and the dangers of using mouthwash with patients with dysphagia 2. Future research should investigate how much and what type of training leads to best practice 3. Oral care protocols need to be developed in care homes
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Author/Year	Purpose	Design	Sample	Intervention	Important Results
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Skin and Wounds Education

22. Large (2011)	Pressure ulcer prevention strategy pilot	<p>Pilot study</p> <p>Audit of patients notes and care plans to assess competence in recognizing pressure damage</p>	78 bed nursing home	<p>6 months best practice care pathway with visits from tissue viability nurse specialist</p> <p>3 hour education session re prevention of pressure ulcers</p>	<ol style="list-style-type: none"> 1. Improvements in patient care 2. Not a huge financial outlay
23. Ousey et al (2016)	Explore pressure ulcer knowledge	Mixed methods	Questionnaire data 65 respondents,	N/A	<ol style="list-style-type: none"> 1. National education programmes are required to develop knowledge and skills

and assess training needs

unregistered and registered across 50 care/nursing homes. Semi-structured interviews across four care and nursing homes and interview data collected from 11 participants (6 RN's and 5 support workers).

2. Little post registration training or education since undergraduate studies
3. Reliance on DN's for advice and support

24. Sprakes & Tyrer (2010)

Would a wound and pressure ulcer framework improve patient outcomes?

Knowledge and skills self-assessment

Pre and post framework knowledge and competence

Training and support for 4 RN's

1. 52% reduction in wound related contacts with others
2. Increased knowledge and skills
3. Reduction in stress

Author/Year

Purpose

Design

Sample

Intervention

Important Results

End of Life Education

25. Baron et al (2015)

Evaluation of education intervention on advance care planning

3 longitudinal questionnaires

265 completed questionnaires including mix of staff – some who had/had

ACP training

1. ACP training for nurses is effective and results in a change in practice
2. Unclear how long the effects of training might last

			not completed training		<ol style="list-style-type: none"> 3. Training might need to be repeated (see Nolan et al , 2008 for further discussion of this)
26. Booth et al (2014)	Evaluation of 3 end of life education initiatives	Evaluation of knowledge pre and post intervention	Mixed cohort	Action Learning Project, 6 Steps to Success programme, Gold Standards Framework programme	<ol style="list-style-type: none"> 1. All three approaches lead to increase in knowledge 2. There are different costs involved with each 3. End of Life educators need to collaborate when they are in the same geographical area
27. Curry et al (2009)	Evaluation of education needs re palliative care	Pre and post assessment	2 nursing homes	15 x 4 hour practice development sessions run by nurse specialists	<ol style="list-style-type: none"> 1. Using practice development framework enables and empowers staff to provide better care 2. Life story work is an important aspect of this work 3. More residents can end their lives in the nursing home rather than in hospital
28. Hasson et al (2008)	Descriptive qualitative study to explore the role of the palliative care link nurse	Exploration of views and experiences	Purposive sample of 14 link nurses from 10 nursing homes – 3 focus groups with link nurses	Link nurse system	<ol style="list-style-type: none"> 1. The link nurse system shows potential to enhance palliative care good practice and training 2. Facilitators of the role included external support, monthly meetings, access to a resource file and peer support among link nurses themselves. 3. Barriers included - Lack of management support, a transient workforce and lack of adequate preparation for link nurses

29. Heals (2008)	Exploration of palliative care link nurse programme 1 year on	Value of link nurse role	16 questionnaires returned	Initial questionnaire to assess knowledge, study days and resource file	<ol style="list-style-type: none"> 1. Study days were valuable 2. Importance of contact with hospice 3. Resulted in changes in documentation and care planning
30. Hewison et al (2011)	Action learning sets with nursing home managers	Evaluation of ALS's	Managers of 22 nursing homes	Initial questionnaire pre ALS Qualitative comments from managers	<ol style="list-style-type: none"> 1. ALS approach resulted in improvements 2. ALS approach good for leadership development 3. Opportunity to discuss practice leads to improvements in care 4. Managers set individual objectives which were supported by other members of the ALS
31. Johnson et al (2013)	Exploration of the complexities surrounding the dying trajectory in 2 nursing homes	Exploration of views and experiences	Interviews and observation of staff, relatives and residents	N/A	<ol style="list-style-type: none"> 1. Education is crucial although alone is insufficient to change practice 2. There is a need for change in working practices, systems and culture to support person centred end-of-life care
32. Knight et al (2008)	Evaluation of palliative care knowledge and skills	Evaluation	Questionnaire to review baseline knowledge. Education needs analysis informed the intervention	A standardized ICP education pack Formal and informal teaching sessions 'Train the Trainer' syringe driver training Matron forums	<ol style="list-style-type: none"> 1. The need for ongoing palliative care education must be addressed locally

				Study days	
33. Lansdell and Mahoney (2011)	Pilot project to facilitate educational programme around end of life care	Competency framework assessed needs in each home	3 care homes. Competency framework to assess individual requirements of each home. Each had different requirements	Educational 5 day course based on competency framework	<ol style="list-style-type: none"> 1. Tailored education lead by care home staff is preferable to the imposition of a course developed from specialist end-of-life care 2. 'A collaborative model of competency development, education, and assessment is proposed to enable a measurable and sustainable improvement in end-of-life care in the care home setting' (p.143)
34. Stone et al (2013)	Qualitative descriptive study exploring the experiences of having ACP conversations	Qualitative study	28 semi structured interviews in 3 nursing care homes (homes undertaking the GSFCH training) ACP is integral to this training	N/A	<ol style="list-style-type: none"> 1. Care home staff need to develop the knowledge, skills, and confidence to engage in discussions around end-of-life care. 2. The assistance of a trained facilitator who role-models the discussions might be beneficial

Education and Mentoring (general)

Four of the included articles discuss the education and training of care home staff and students generally without link to a specific clinical or medical focus (Banning et al, 2006, Lees et al, 2006, Rout et al, 2010, Allan, 2010). Designs of the studies range from a training needs audit to an interpretive ethnographic study. Allan (2010) reported on interviews undertaken as part of a wider ethnographic study about the mentorship of overseas nurses ('Researching Equal Opportunities for Overseas Nurses and other Healthcare Workers study). Using a generic qualitative approach, Rout et al (2010) examined the influences on learning and development in care homes for health care assistants and assistant practitioners. One study (Banning et al, 2006) used an illuminative evaluation approach to explore the use of care homes as pre-registration nursing placements. Utilising a training needs audit, Lees et al (2006) explored the training needs of nursing staff across ten private nursing homes. Examining the results, Allan (2010) suggests that overseas nurse are treated unfairly and experience discrimination during supervised practice in UK care homes. Problems included lack of mentor preparation and confusion about the status of overseas nurses. Recognition needs to be given to the fact that overseas nurses have been trained in a different system to that seen in the UK and have different learning styles. Cultural differences affect mentorship and learning, and more attention needs to be paid to these factors. Rout et al (2010) used semi structured telephone interviews to explore learning and development needs in care homes and found multiple barriers to ongoing learning and development summarized below.

Barriers to Learning & Development

- Funding
- Staffing constraints
- Work–life balance
- Lack of career progression
- Study skills
- IT issues
- Lack of staff and management engagement
- Lack of course flexibility
- Lack of marketing

Rout et al (2010: 290)

Following on from the research, the Lifelong Learning Network (LLN) has developed a study skills module to support those staff members wanting to access higher education. For effective education, flexible learning opportunities for staff, clear progression routes and manager engagement are some of the suggestions made following the study. Banning et al (2006) involved nine nursing homes and a sample of ten student nurses to explore the use of care homes as placements. Utilising a questionnaire method they found that care homes were initially not viewed as effective placements by students who perceived care homes as being inferior to hospital placements, feeling they would learn less if placed there. However by the end of the placement, the students felt they had learned some fundamental skills and gained a holistic view of care, skills which could be applied in the acute setting in future. Care home staff were found to be friendly and supportive and the students experienced a positive mentoring experience. Lees et al (2006) training needs audit was undertaken across ten care homes in Birmingham, examining eleven core areas of clinical nursing skills identified by the East Birmingham Care Homes Strategy

Group (EBCHSG). Three main areas of training need were identified; falls, confusion and diabetes. A finding repeated throughout the audit process was that of the need for ongoing support for nursing staff who are often working in isolation in the care home setting.

Chronic Disease and Ongoing Conditions

Three studies explored educational interventions relating to chronic disease management and ongoing conditions, two on the subject of diabetes care (Heeley-Creed et al, 2007, Shepherd et al, 2008) and one on stroke education (Smith et al, 2008). Heeley-Creed et al (2007) evaluated the implementation of a diabetes training programme pre and post intervention. Similarly Shepherd et al (2008) evaluated a programme aimed at improving knowledge and care of diabetes. Smith et al (2008) undertook a survey to assess the educational priorities in relation to stroke care among care home staff.

Both of the diabetes focused studies evaluated the impact of training programmes for care home staff. Following the implementation of a diabetes training programme Heeley-Creed et al (2007) found that tailoring training to the requirements of individual care homes supports improvements in diabetes care for residents. Pre course information improved attendance and post course educational materials left at the home were helpful for staff. The authors recommend the development of a protocol which can be used to assess the quality of diabetes care. Shepherd et al (2008) reported on the Pan Peninsula Diabetes Education Initiative which involved 484 staff in 115 care homes including qualified staff, support workers, managers and cooks. The programme resulted in a raised awareness of diabetes and the development of a foot care programme. The authors report the need for a rolling

programme of education due to the high turnover of staff. Smith et al (2008) used a survey to assess the educational needs of care home staff, a mixed cohort of 115 qualified staff and 19 support workers). Staff reported the need for more stroke education and the development of guidelines on stroke care. Prohibitive factors to development included lack of knowledge of training opportunities, lack of employer encouragement and staff shortages.

Continence

One study explored continence education (Rodriguez et al, 2007). A continence survey was developed and sent to 186 care homes to assess continence prevalence, knowledge and care. 66 surveys were returned and the results showed knowledge gaps, for example, in relation to the belief that incontinence is linked to increasing age. The authors recommend partnership working with other services as a way to improve practice in continence care.

Delirium

Two studies reported on delirium education although both relate to the same project, 'Stop Delirium!' (Featherstone et al, 2010, Siddiqi et al 2011). Featherstone et al (2010) utilized interviews and questionnaires to assess changes in staff knowledge following implementation of the educational package. As part of the project a full time delirium practitioner worked with staff across 6 care homes over a 10 month period. Findings suggest that flexibility in terms of length and timing of education sessions reduced the impact on home staffing levels. Manager support was important to the intervention to be successful and encouraging staff ownership of the materials made them a more effective resource. Sharing resources across the 6 homes was a helpful process. Additional findings from Siddiqi et al (2011) suggest a reduction in the

number of falls and prescribed medications following the intervention and an increase in staff confidence. Providing training in the afternoon was helpful and some staff showed additional enthusiasm for the subject area which led the authors to suggest the potential for training of delirium champions.

Dementia

Seven studies reported on dementia education (Hughes et al, 2008, Khan & Curtice 2011, Livingston et al, 2012, Board et al, 2012, Brown-Wilson et al, 2013, Elliot et al, 2014, Velzke, 2014). Hughes et al (2008) undertook a study sending questionnaires to 500 randomly selected care homes. 30 additional homes were sent questionnaires and took part in telephone interviews. Khan & Curtice (2011) evaluated a 6 month pilot project exploring a dementia in reach service to 4 care homes using pre and post intervention questionnaires. Livingston et al (2012) undertook a qualitative study on the subject of end-of-life care utilising interviews of 58 staff in a 120 bed home. Board et al (2012) evaluated an educational intervention with 20 staff although it was unclear what methods were used to evaluate apart from the documentation of thoughts about sessions using Post-it notes. Brown-Wilson et al (2013) utilized a mixed methods approach with 11 staff using a pre and post intervention design to evaluate an educational intervention. Elliot et al (2014) evaluated an educational intervention in 1 large care home using written feedback forms. Velzke (2014) evaluated a learning programme using a mixed method approach.

Examining the results, four studies evaluated the impact of an education intervention. (Board et al, 2012, Brown-Wilson et al, 2013, Elliot et al, 2014, Velzke, 2014). Board et al (2012) evaluated the effect of a dementia education programme delivered 1 day per week during 5 weeks. 20 staff were involved (mixed cohort)

working at 3 of Colten Care group homes. The results revealed that staff liked informal and interactive sessions which involved the views of carers. The success of the intervention resulted in the University of Bournemouth endorsing an educational package for future use. Brown-Wilson et al (2013) developed and delivered 8 workshops relating to the principles of relationship centred care to 11 staff (mixed cohort). Education through the use of facilitated workshops was shown to be helpful to care delivery and proves an effective way to support changes in practice.

Utilisation of the 'Senses Framework' (see Nolan et al, 2006) through a workshop approach, encouraged staff to consider personal strategies to develop their practice. Elliot et al (2014) report on distress reaction training delivered by 'My Home Life Admiral Nurses' (mental health nurses specializing in dementia). When residents with dementia experience distress this leads to a higher burden being placed on staff. The intervention was evaluated using feedback forms and it is suggested that scenario based interactive training was helpful to the staff. Velzke (2014) evaluated the Dementia Services Development Centre 'Best Practice in Dementia Care' Learning Programme. Using a multi method approach which incorporated 100 feedback questionnaires, 60 reflective exercises and 89 online responses to a manager survey, they found that the intervention have increased awareness and understanding of dementia. They suggest that the course had led to an increased use of evidence based care and resulted in more effective interaction between staff, carers and residents. Hughes et al (2008) explored the knowledge and confidence levels of staff dealing with people with dementia. One of the aims was to identify factors contributing to greater confidence in staff dealing with people with dementia. The findings suggest that training can increase the quality of care provision and the mode of educational delivery and setting in which this takes place is important. The

authors suggest that effective leadership and an open and honest culture is required to promote an effective educational environment. Livingston et al (2012) used qualitative interviews to explore end-of-life care to people with dementia. They found that staff at all levels require further education on this aspect of practice particularly on discussion and implementation of care plans. The authors found lack of a team approach, poor understanding of specific religious practices and poor communication between members of the care home team when dealing with residents with dementia at the end-of-life. Khan & Curtice (2011) evaluated a pilot project involving 4 care homes who had taken part in the Care Home In Reach Programme (CHIP). This included the training of care home staff in the behavioral and psychological symptoms of dementia with particular focus on the use of antipsychotic medication vs non pharmacological approaches. They found a need for further extensive education and training with some improvements in knowledge and confidence evidenced at the end of the CHIP experience.

End of Life

Ten studies explored end of life education for staff in care homes (Hasson et al, 2008, Heals, 2008, Knight et al, 2008, Curry et al, 2009, Lansdell & Mahoney, 2011, Hewison et al, 2011, Stone et al, 2013, Johnson et al, 2013, Booth et al, 2014, Baron et al, 2015). Hasson et al (2008) utilized a descriptive qualitative approach involving 14 palliative care link nurses across 10 care homes. Heals (2008) evaluated the impact of a palliative care link nurse education programme aimed at providing ongoing education and support for staff caring for the dying. Knight et al (2008) report on an educational needs analysis undertaken prior to training in the use of an integrated care pathway (ICP). Curry et al (2009) evaluated the palliative care education needs of care home staff in 2 nursing homes, undertaking a pre and post

assessment of knowledge following 15 x 4 hour practice development sessions run by palliative care nurse specialists. Lansdell & Mahoney (2011) reported on a pilot project exploring the effect of a competency development package to support improvements in end-of-life care in 3 care homes. Hewison et al (2011) undertook an evaluation of Action Learning Sets with care home managers, utilizing questionnaires and qualitative comments to assess the impact. Two studies explored the subject of Advanced Care Planning (ACP). Stone et al (2013) utilized a qualitative descriptive approach and Baron et al (2015) evaluated an educational intervention using the method of longitudinal questionnaires. Johnson et al (2013) used a broad qualitative methodology to explore the complex nature of the dying trajectory in 2 nursing homes. Booth et al (2014) evaluated 3 end of life education initiatives, assessing staff knowledge pre and post intervention.

The role of the palliative care link nurse was explored in two studies (Hasson et al, 2008, Heals, 2008). Both studies reported that the link nurse system has potential to enhance palliative care good practice in the homes. Hasson et al (2008) suggest the need for management support for the system to be effective and cited barriers such as the transient workforce in care homes and lack of adequate preparation for the link nurses themselves. Heals (2008) reported the value of study days for care home staff, the importance of contact with the hospice and the implementation of an educational resource file. Knight et al (2008) suggest the need for sustainable local palliative care education. Their intervention included formal and informal teaching sessions, syringe driver training and study days. The study days were facilitated through a partnership approach, involving Macmillan Cancer support, who funded the study days, and the local palliative care teams. Curry et al (2009) explored the educational requirements of staff in 2 care homes using a practice development

framework. Practice development sessions were implemented by palliative care nurse specialists and this had an enabling and empowering effect on staff and supported them in providing improved palliative care to residents. Ultimately this means that more residents can end their lives in the home rather than the hospital environment. Landsell & Mahoney (2011) report on the development of a competency framework across 3 care homes in which the competencies were developed in collaboration with the care home staff. This meant that the individual competency statements could be tailored to meet the relevant needs of each home. Following this was the delivery of a 5 day course which acknowledged the individual competency statements of each home, which led to the development of a resource package tailored to each care home. Hewison et al (2011) evaluated the use of the ALS with care home managers, working on the assumption that effective end-of-life care requires strong leadership. The ALS approach was viewed as effective approach for leadership development as it afforded an opportunity to discuss practice which in turn was felt to lead to improvements in care provision. Using this approach the managers set individual objectives which were supported by other members of the group. Baron et al (2015) evaluated an educational intervention on ACP. 265 questionnaires were completed including some staff who had not completed the ACP training. The findings suggest that ACP training is effective and results in a change in practice although it is unclear how long the effects of training last for. Stone et al (2013) used semi-structured interviews to explore experiences of having ACP conversations. 28 interviews were carried out across 3 homes with staff undertaking the GSFCH training. The use of trained facilitators who role model the ACP discussions was suggested to be beneficial in supporting others in developing competence in this area. Johnson et al (2013) explored the views and experiences of

the dying trajectory through interviews with staff, relatives and residents in 2 homes. The ability to diagnose and have an awareness of dying was considered important and an area in which it was felt there was no substitute for experience. Education and training was viewed as important in key areas and described as a way to build confidence in staff. However the authors highlight that changes in practice will not come about through education alone, and culture shifts are required to support person centred end-of-life care in homes. Booth et al (2014) evaluated 3 end-of-life education initiatives; an action learning project, a Six Steps to Success care home programme, and a Gold Standards Framework for Care Homes programme. The authors concluded that all 3 approaches led to an increase in knowledge among staff and a recommendation that end-of-life educators need to collaborate when they are located in the same geographical area, as a way to build on effective practice. The authors make the point that it is often the 'progressive' homes that are prepared to invest in programmes like these, which might be viewed as costly. The homes who would benefit the most from engaging in ongoing education might be those most difficult to reach, and there needs to be a way to engage with those staff who have had little or no training and education in this aspect of practice.

Falls

Three studies explored education related to falls and falls prevention (Mitchell & Lawes, 2007, Cox et al, 2008, Borland et al, 2012). Approaches ranged from an audit of learning to a randomized controlled trial exploring the education of nursing home staff in this aspect of practice. Mitchell & Lawes (2007) undertook audits across 2 Primary Care Trusts in 2004/5 which identified weaknesses in the provision of training at that time. Cox et al (2008) reported on a pragmatic cluster randomized control trial which explored the education of care home staff and associated link with

resident fracture prevention. The study by Borland et al (2012) utilized an exploratory descriptive survey approach to gain understanding of nurses' knowledge of appropriate footwear choice for older people in care homes.

Mitchell & Lawes (2007) report on a falls education programme which was introduced following an initial audit undertaken in 2004. The programme offered three different styles of educational intervention; an e-learning package, an independent learning manual and group training sessions facilitated by 'falls champions'. The authors conclude the need for education in order to decrease the likelihood of falls and the importance of giving consideration to participants' individual learning styles. The trial by Cox et al (2008) examined the use of specialist osteoporosis nurses delivering short training sessions with care home staff in order to support identification of residents at high risk of fractures and emphasise the importance of falls prevention. The educational intervention led to an increase in the prescription of bisphosphonates and calcium/vitamin D although this was not associated with the rate of falls or fractures. The study by Borland et al (2012) explored nurses' views about what constitutes safe footwear for residents. The link between safe footwear and falls was recognized by 80% of respondents although nurses had several views about what constituted safe footwear. The authors recommend improved safe footwear education and the development of guidelines for educators to inform students about suitable footwear choices for residents in care homes.

Oral Care

A 20 item questionnaire was completed by 53 registered nurses working in 6 care homes in a study by Durgude & Cocks (2011). The aim of the study was to assess

the level of knowledge of oral care and the role of the Speech and Language therapist. Results showed that the nurses required further education in areas such as oral health and drugs and medical conditions which might impact on poor oral health. They recommend the development of oral care protocols and the need for future research to explore the type and duration of educational interventions which lead to best practice.

Skin and Wounds

Three studies explored education of care homes staff on the subject of skin and wounds (Sprakes & Tyrer, 2010, Large, 2011, Ousey et al, 2016). Studies ranged from a pilot study of a pressure ulcer prevention strategy to a mixed methods design. Sprakes & Tyrer (2010) implemented a wound and pressure ulcer competency framework in one care home supported by the community skin care service. Large (2011) implemented a pressure ulcer prevention strategy in a pilot study in one care home. This involved visits from a tissue viability nurse specialist and a 3 hour education session about pressure ulcer prevention. Ousey et al (2016) undertook a mixed methods study across 50 care homes to explore pressure ulcer knowledge, including staff knowledge of the development of pressure ulcers being viewed as a safeguarding issue.

Sprakes & Tyrer (2010) report a reduction in stress among the four registered nurses involved in the project, increased knowledge and skills and a 52% reduction in wound related contacts with other professionals (for example, district nurses). Large (2011) reports an improvement in patient care based on changes made, for example, the use of barrier creams, without the need for a large financial outlay for the home. Ousey et al (2016) suggest the need for national education programmes to develop

knowledge and skills in this area of practice. Staff taking part in the study reported little post registration education or training on the subject since their undergraduate nursing studies, and there was a need to rely on district nurses for advice and support.

Discussion

The review revealed a number of important findings helpful when attempting to understand effective educational approaches in care homes in the UK. The majority of the studies involved small sample sizes and only one randomized controlled trial was located (Cox et al, 2008). Considering the hierarchy of evidence suggested by Greenalgh (2014) there was a lack of high quality research located in this area. This made it difficult to assess whether any of the reported interventions were successful, or changes in practice were due to other factors occurring simultaneously, for example, Sprakes & Tyrer, (2010) and Large, (2011). Nonetheless, reviewing the studies as a whole, provides some helpful information on educational practice in care homes and the fact that there were so few high quality studies located, is a telling finding in itself.

Types of educational intervention

20 studies reported on educational interventions with a specific clinical focus and of these 14 used a pre/post design to evaluate the effectiveness of the intervention (Heeley-Creed et al , 2007, Mitchell & Lawes, 2007, Shepherd et al, 2008, Curry et al, 2009, Featherstone et al, 2010, Sprakes & Tyrer, 2010, Hewison et al, 2011, Khan & Curtice, 2011, Large, 2011, Siddiqi et al, 2011, Brown Wilson et al, 2013, Booth et al, 2014, Velzke, 2014, Baron et al, 2015). All of the 14 studies reported an

increase in knowledge amongst staff following the intervention. However some studies involved small sample sizes, for example, Sprakes & Tyrer (2010) implemented a wound and pressure ulcer framework for 4 registered nurses, making it difficult to make generalizations from the findings.

In relation to palliative care there are many assumptions made about staff working in care homes (Froggatt, 2001) as follows:

Models from specialist settings can easily be applied to care homes

Cancer palliative care models are applicable to all those dying in care homes

There is a lack of knowledge among staff and education is enough to bring about changes in practice.

Indeed rather than apply specialist models, the need to tailor training to the requirements of the individual home was highlighted in a number of studies, for example, Heeley-Creed et al, (2007) in their work on diabetes care, Mitchell & Lawes' (2007) work on falls education and Lansdell & Mahoney's (2011) in their work on end-of-life care. Lansdell & Mahoney (2011) provide detailed discussion about the need to work collaboratively with care home staff, to address their individual needs rather than imposing general competencies. This individualized approach led to the development of a resource package, tailored to the needs of the individual home rather than adopting a one size fits all style. If staff feel they have ownership of the materials developed through the interventions, they become more effective as a resource (Featherstone et al, 2010).

The type of educational method used to deliver the interventions was discussed by some authors (Curry et al, 2009, Board et al, 2012, Brown Wilson et al, 2013, Stone et al, 2013). Teaching sessions that are informal, flexible, personalized and

interactive were shown to be the most effective when engaging staff in learning. Hewison et al (2011) describe the use of action learning sets to engage home managers in education about end-of-life care. A supportive and personalized environment was shown to be effective in engaging the participants in discussing and reflecting on practice. Stone et al (2013) suggest the use of role modelling when supporting staff development around advanced care planning discussions. This approach provides opportunities for staff to emulate good practice in this area.

The role of the link nurse was discussed in two studies in terms of supporting good practice in palliative care provision in care homes (Hasson et al, 2008, Heals et al, 2008). Indeed many of the studies reported on the use of external experts to deliver education to the care home staff. However due to the high turnover of staff in care homes, a rolling programme of education might be required to ensure all staff receive the same interventions (Shepherd et al, 2008). This could become costly and wider thinking around education is required. Speaking from a palliative care perspective, Johnson et al (2013: 103) state;

'Education is a crucial aspect affecting the provision of high-quality care; however, education alone will not be sufficient to change practice. Working practices, systems and culture also need to change so they support the principles of person-centred end-of-life care'.

It could be argued that these sentiments are applicable to all aspects of education in care homes and the need for robust and sustainable interventions are required. In terms of promoting sustainability of educational projects, there were a number of issues identified in the literature. Lansdell & Mahoney (2011) suggest linking staff needs identified in the end-of-life competency framework to staff appraisal, thereby

promoting sustainability beyond the life of the project. However barriers were identified which discouraged sustainability of educational projects. Sprakes and Tyrer (2010) cite lack of resources as the barrier prohibiting them from undertaking further work to assess the sustainability of their project relating to pressure ulcers and the implementation of a framework to improve resident outcomes. One of the aims of the pilot was the authors to engage with the care home owner, to support sustainability of the improved level of care although this aspect of the project was not reported on further. There were further barriers to education reported in the studies succinctly summarized by Rout et al (2010) in Table 4. These identified barriers were evident in many of the studies and in some cases led to staff dropping out of projects being undertaken.

Barriers and drivers

Focusing on barriers to education, Lansdell & Mahoney's (2011) study on end-of-life care reported that one care home had to discontinue due to staffing difficulties. Out of an initial number of 22 managers expressing interest in taking part in the ALS approach reported by Hewison et al (2011), only 1 ALS was developed for the 12 applicants who signed up for the study. Further, of these original 12, only 8 attended 2 or more meetings. 2 participants were unable to attend due to increased workload resulting from staff shortages and due to being transferred to another home at short notice. Smith et al (2008) report prohibitive factors such as lack of knowledge of training opportunities, lack of employer encouragement and staff shortages. Problems related to a transient workforce were reported by Hasson et al (2008) and inadequate preparation of the link nurses in the study was another barrier to effectiveness. Pre conceived ideas about care homes led to students viewing them as inferior to learning in acute settings (Banning et al, 2006). However these

perceptions changed by the end of the student placement with students feeling they had learned essential nursing skills in a holistic setting. Ousey et al (2016) suggests that nurses working in care homes had received little training since their undergraduate studies. It could be argued that qualified nurses have a responsibility to maintain their competence and this is an NMC requirement for revalidation (NMC, 2015). However if older persons nursing is not viewed as a speciality but more of a job of convenience, there might be little motivation to complete further study. In addition to the barriers outlined earlier, it is unsurprising that nurses might not be inclined to seek out opportunities for training and education.

On a more positive note, a finding in many studies was the effectiveness of collaborative working at all levels. On the subject of continence, Rodriguez et al, (2007) suggests the requirement for partnership working with other services would improve practice in continence care. Heals (2008) suggested regular contact made by care home staff with the hospice was effective when caring for residents at the end-of-life. Sharing materials on delirium with other care homes was shown to be helpful by Featherstone et al (2010) and the need for end-of-life educators to collaborate with those in the same geographical area was a recommendation made by Booth et al (2014).

What seemed prominent in this review was a 'dependency' model of education and training whereby education was delivered by 'expert others' who visited the care homes and then left. Problems were identified in relation to sustainability of educational approaches and there seemed little discussion about the ways in which care home staff might be empowered to take responsibility for their own individual learning needs on an ongoing basis. As suggested by Frogatt (2001) there is an assumption that external specialist models can be applied to care homes and this

might not always be the most suitable option for education provision. Indeed a lot of the positive findings in this review arose from interventions which were tailored to the specific home.

There seemed to be an assumption in many of the studies that the implementation of training and education would lead to changes in practice. As Johnson et al (2013) suggest, although education is important, there is a need for a wider culture shift if changes in practice are going to occur. Across the located studies there was little mention of the need for experiential learning and the value of reflective practice. The lack of this finding might have occurred due to the nature of the search strategy, although it is an issue which can be picked up in the subsequent appreciative inquiry. Attendance at a course or study session might be valuable although it is the ongoing reflection and associated thinking which might lead to more sustainable changes. A suggestion made in a number of studies was the need for networking across homes to share resources and opportunities for peer support, mentoring and clinical supervision could also be developed in this way. Care home nursing can be isolating particularly for qualified staff who work with a higher proportion of support workers than their acute hospital peers (Spilsbury et al, 2011). Opportunities for joint reflection and clinical supervision could be an excellent way to share ideas and think about practice. This discussion will be developed in the final part of this report.

Summary

- Educational interventions in care homes tend to have a medical focus and are delivered by 'expert others' leading to a dependency model rather than an empowering approach to education

- Nursing staff face multiple challenges when trying to access education in care homes
- Interventions seem to have an effect on care in some cases although the sustainability of this is unknown
- Education that is tailored to the individual care home and staff is effective
- Care home nursing staff enjoy flexible education approaches delivered on site
- Staff often have to discontinue their education due to short staffing in care homes

Methodology: Appreciative Inquiry

Appreciative Inquiry (AI) is an approach to organizational change which focuses on the strengths of an organization rather than its weaknesses (Elliot, 1999). It can be described as a process, having a number of steps which can be used when working with an organization, but also as a philosophy. At its core, AI supports a collaborative approach and views change as a journey rather than an event. AI values the best in people and organisations working on the assumption that there is positive practice to be found everywhere (Martinetz, 2002). Exploring what works well brings energy to teams; celebrating success and encouraging positivity supports teams to move on with a collective forward thinking vision. It is easier to move forward into the unknown when staff can bring with them positive and familiar parts of the past. Conversely, focusing on problems can limit thinking, and there are multiple issues surrounding care homes which have been documented at length (see for example Mason, 2012). It was our aim to celebrate effective educational practice and consider ways to promote this, rather than identify problems which we already knew existed, which relate to both qualified and unqualified groups of staff.

Care home work can be viewed by nurses as an unattractive career option and one of low status. This can be due to experiences during pre-registration nurse education and socialization (Henderson, 2008). The desire to work with older people is shown to decrease over the duration of undergraduate nursing programmes (Stevens, 2011) and this has implications for choice of nursing career upon qualification. Care home nursing is seen as an area of practice with little innovation, development or professional opportunity. Care home nurses have less access to educational opportunities when compared to their NHS colleagues and a large amount of staff are from overseas. This creates educational challenges related to support, supervision, CPD and retention (Spilsbury et al, 2015).

As a research approach, AI has been used effectively by others in various settings; see for example, Carter, (2006), who used AI to explore children's services; Leibling et al (2001) and their work with the prison service and Lavender & Chapple's (2004) work with maternity services. According to Hammond (1998: 20) there are eight assumptions about AI which summarises its philosophy well:

- In every society, organization or group, something works
- What we focus on becomes our reality
- Reality is created in the moment and there are multiple realities
- The act of asking questions of an organization or group influences the group in some way
- People have more confidence and comfort to journey to the future when they carry forward parts of the past
- If we carry parts of the past forward they should be what are best about the past
- It is important to value differences
- The language we use creates our reality

As Carter (2006) suggests the success of AI as a research approach depends on both the 'philosophical orientation of the researchers and their inter/intrapersonal skills' (p. 7). There were three overarching reasons why as researchers we considered AI to fit well with the proposed care home research. These were grounded in our research orientation and also the perceived view of care homes as a setting for education and development. Coming from a qualitative background AI seemed a good 'fit' with our own research philosophies. AI studies engage

participants in telling stories of good practice, of future dreams, of miracles and hopes – all of which fit well with our previous approaches to research. As qualitative researchers, we do not view research as ‘problems to be solved’ preferring an exploratory approach, which AI seemed to facilitate. Finally, we were aware of the negative image of care home nursing, one which is not viewed as a valid career choice, supported by the problems with recruitment and retention of staff. This was an opportunity to celebrate all that is good about care home nursing and consider ways in which effective practice can be developed and promoted.

There are four main stages within AI: Discovery, Dreaming, Design and Destiny as described below:

Stage	Description
Discovery	This phase explores ‘the best of what is’ and tries to determine what gives life to the organization. Staff were asked to describe their best time in the care home in terms of education/development and the surrounding factors (skills, attitudes, support) required for this to happen
Dream	Dream explores ‘what could be’ and asks the ‘miracle’ question, to create a positive vision of what might be if there were no restrictions, thinking that anything is possible. Staff were asked what they would like if they could have a miracle of could be granted three wishes for an ideal world. From this are developed the Provocative Propositions – statements of what could be.
Design	Design explores ways in which the vision can become a reality, based on previous good practice. Care home staff were asked to think about how their vision for the future could be achieved.

Destiny

Destiny involves thinking about ways to create a new future, combining the Dream and Design phase to build an 'appreciative' way of working. This phase would involve the wider team, including those at a strategic level, if the vision was to be realized.

Method

Using an AI approach, we conducted 15 appreciative interviews and facilitated 4 workshops. Purposive sampling was used during the interview phase and staff who were involved with the Foundation of Nursing Studies project work were invited to be interviewed. These staff were chosen as they were familiar with the Teaching Care Homes project and had been involved in workshops to support development of their projects to develop care home practice. The Workshops were more open and sampling tended to be convenience, with staff (predominantly carers) attending if they could be spared from their work. Data were collected between September 2016 and February 2017.

The individual interviews were undertaken with the teams at the study sites, in the care homes, in a quiet place. Often this was in a lounge or in the manager's office. The interviews were audiotaped and lasted between 23 and 70 minutes. The workshops were not audiotaped as we wanted to encourage the participants to talk freely about their development within the organization. Further, we requested that they worked creatively, and wrote a song or poem about their vision for the future, and audiotaping this might have left them feeling vulnerable. Therefore to encourage freedom of expression, we made notes during the workshops rather than tape recordings. The questions and prompts used in both the interviews and workshops

are listed below and reflect the Discovery, Dream and Design stages of the AI approach. All of the individual interviews were undertaken with one researcher and for logistical reasons, 2 of the workshops. The remaining 3 workshops were facilitated by 2 researchers with one taking the facilitator lead and the other, making notes. The data were analysed by 2 researchers followed by discussion until a consensus was reached.

The researchers have already worked with student nurses using creative methods of data collection with great success (see Jack 2015, Jack & Tetley, 2016, Jack 2017). These methods included the use of collage as a means of emotional exploration and reflective poems to consider the meaning of compassion with student nurses. Working creatively leads to more meaningful exploration of issues under discussion enabling a freedom of expression in the participants. Using creative approaches seemed to fit well with AI and the use of generative questions inherent in this approach. As Liebling et al (2001) suggest, generative questions call for answers which are illustrations and stories, so the use of creative approaches would facilitate this well. Further, a belief of AI is that the language we use creates our reality and using positive language supports different realities, which might relate to positive ways of learning and development in the care homes. Therefore, during the workshops we asked the participants to write a poem, song or rap, of a 'new world' of education and development. We hoped that doing this might lead to a positive way of thinking about the future and the participants might tap into what is important to them as carers and their hopes for positive future careers.

Ethics

Ethical approval was gained prior to the start of the study, from Manchester Metropolitan University Ethics Committee (Faculty of Health, Psychology & Social

Care Reference 1376). Information sheets were distributed to the 5 care homes 2 months before the data collection commenced. Consent forms were signed prior to commencement of the data collection and staff were informed of the confidential nature of the data and the option to withdraw at any time during the study.

The following is a summary of the Interview and Workshop prompts and plan:

Individual Interview Prompts

Discovery (the best of what is or has been)

Here we want to elicit discussion about experiences, memories and values (the aim is to get specific examples of real life experiences wherever possible)

Prompts:

Can you tell me about your best time in care home education/development in terms of producing effective work (this might be facilitating learning in another or involve themselves in a learning situation)

Can you tell me about a particular piece of work which illustrates your best practice in care home education?

How was this supported and enabled?

What specific talents/skills/attitudes did you bring to this work?

Any other examples of success you can think of?

Dreaming (what might be)

Here we are trying to elicit statements that sum up 'what could be'. These are powerful as they have been generated by the participants based on their own experiences and values and involve the resources of the organization.

Prompts:

Imagine a miracle has occurred and this means you can do your best quality educative work all of the time – what would be different in the wake of this miracle? (this might be different for managers and carers e.g. for manager it might be about having more mentors, for carers it might be about themselves having more opportunities for education and training)

What difference would this miracle make to your life?

What would be your 3 wishes for care homes (in terms of staff development and education)

Identify one small thing that would make a difference overnight?

Dreaming/Design (what might be/what should be)

What does the ideal look like?

What is needed to make your vision a reality?

This is based on examples of previous successes and achievements the staff have had in the past

From this we will end up with a series of provocative propositions agreed on by the group e.g.

Everyone has access to development and training and this is available and flexible to need

Staff have a choice about the areas of training they want to access and this is linked to their PDR

Exploring AI as a research method

This is a debrief stage designed to explore the use of an appreciative stance (see Robinson et al, 2012).

Prompts:

How was the interview for you?

What was it like being asked to talk about your best work?

How easy was it to find examples of good practice?

How often do you get to talk about your successes, strengths and best work?

(We want staff to talk reflectively about how it felt to be interviewed appreciatively, rather than using a problem focused approach to research – this is important in terms of developing effective research strategies for future use. This might be particularly important when considering the media attention surrounding care homes which is often negative/challenging)

Format of Group Workshops

Aim:

To gain greater understanding of the factors which promote effective staff development and learning in care homes

Objectives

By the end of the session we will be able to:

Discuss the range of learning styles in the group: how/when/why do people like to learn?

Identify instances of good education/development practice already experienced by the group

Analyse the drivers for further effective developmental experiences

Identify 5 – 10 provocative propositions (statements generated by the group, about what would happen in an ideal world e.g. 'Everyone has access to flexible and appropriate development and training')

Plan

(this is flexible depending on how many and for how long staff can attend)

Time	Focus	Activity	Resources	Evaluation
10 mins	Introductions and aim of session	Verbal presentation	-	Verbal feedback
20 mins	Activity 1: To identify individual learning styles and perspectives in the group	Choosing from a selection of picture cards	Picture cards	Individual feedback from group members
20 mins	Activity 2: To identify what makes an effective learning experience and identify 3 ideal world wishes	Drawing in pairs	Flipchart paper and pens	Paired feedback
BREAK				
30 mins	Activity 3: To identify a 'new world' of staff education and development	Song/poetry writing	Paper and pens	Feedback of song/poem/rap
20 mins	Activity 4: Generate propositions	Whole group discussion	Flipchart paper and pens	Whole group feedback
10 mins	Close	Verbal presentation	-	Feedback from group

Activity One

Choose a card that best describes you as a learner/the way in which you like to be developed. How/when/why do you like to learn?

Present your thoughts to the whole group.

Activity Two

Now in pairs, discuss a time when you felt that you had a really good learning experience. It might have been when someone took a real interest in you, spent time explaining something to you or when someone showed you a new skill.

Talk about what you learned.

How did it feel?

What was good about the learning and experience?

Be prepared to present this back to the whole group

Now imagine an ideal world and you have been granted three wishes.

In terms of your own development, what would these wishes be? E.g. time, learning a particular skill etc...

Draw these wishes on the paper and then present them back to the group.

Activity Three

Finally, in pairs/groups write a poem/song/rap about a new world of staff development. How would it look and feel? This is based on what you have discussed so far.

Activity Four

The facilitators develop 5 – 10 provocative propositions with the group based on what they have said during the session

(During the whole session the facilitators are considering the provocative propositions which are then discussed and agreed with the whole group – it is important that these are generated by the group)

Analysis

The interview data was analysed using an adapted version of the Framework Analysis method described by Ritchie & Spencer (1994). They describe a 5 step process which is flexible and enables researchers to analyse during the collection process:

1. Familiarisation (the researcher becomes familiarized with the data collected)
2. Identify a thematic framework (recognition of emerging themes and issues arising from the data)
3. Indexing (sections of data that respond to a particular theme are identified)
4. Charting (data is arranged into charts of the themes)
5. Mapping and Interpretation (the whole data set is mapped and interpreted. This stage will include the finding of associations in the data, explanations within the data and the development of strategies)

Srivastava & Thomson (2009) suggest that Framework Analysis is suited to research that has a specific question, a limited time frame, a pre-designed sample and a priori issues (p.72). Whilst the research did not necessarily seek to answer a specific question, the aim was to explore the conditions in which education and development can thrive, therefore it did have a particular focus which required exploration. In line with the 5 stages the transcripts were read by both researchers along with the findings of the Scoping Study, Workshops and other relevant contemporary documents. Recurrent themes were noted and discussed on an ongoing basis as part of the familiarization process. As suggested by Ritchie & Spencer (1994) it is important that the data drives the analysis and this forms the basis of the framework, with the researchers keeping an open mind throughout.

An extract from the framework and indexing stages is provided below, taken from the Care Home Manager interview data:

Individual Interview Prompts (extract) Indexing (extract)

Imagine a miracle has occurred, what would be different?

Continuing Professional Development

1. *Specialist routes*
2. *Experiential learning*
3. *More resources*

What difference would the miracle make to your life?

1. *Developing talent*
2. *Cost effectiveness*
3. *Retention of staff*

Notes:

Frustration at under resourcing

Need for long term vision to recruit and retain staff

Need for flexibility for CPD

The framework was used to support the charting, mapping and interpretation stages, using headings and sometimes subheadings in order to thematically present the data. At this stage data is taken out of its context, although it still needs to identify with the case it came from. To make this stage more explicit, we decided to keep each data set separate; the Care Home Managers, Qualified Staff and Carers.

Further, presenting the data separately, enables readers to immediately access

areas of interest, without having to sift through all of the data to locate a relevant part. Each group had different priorities, experiences and expectations therefore keeping these separate was a coherent way to proceed.

The final stage of mapping and interpretation includes analysis and the explanation and development of strategies. This must relate to the data and reflect the true values and beliefs of the participants. This method of analysis fits well with the AI approach which is grounded in working *with* participants in a collaborative manner. The research was commissioned to explore the attitudes, experiences and behaviours of nursing staff working in care homes in order to identify the conditions in which education and development can thrive in this environment. Through the data analysis we were able to describe strategies for change and these ideas arose directly from the data we collected. For example, the Care Home Manager data identified issues relating to staff recruitment. By considering the implications of these issues, a strategy can be developed to inform a way forward in this area. Further, this can inform the Destiny stage of AI:

Change Perceptions of Care Home Work

Need to attract younger people into the home to dispel myths about older people and negative stereotypes of the setting, engage student nurses and expose them to positive experiences in homes

Develop Incentives

Offer career routes for example, from carer to manager, develop more specialist routes for qualified nurses, offer support for staff development

Raise the Profile of the Care Home

Develop and advertise care home nursing as a rewarding career choice, one which can support the development of autonomy, managerial skills and high levels of responsibility and reward

Summary

- The use of AI as a research method ensured a collaborative approach to explore effective educational practice in the care homes
- AI enabled the researchers and participants to identify positive educational practice already in place
- Working creatively with the participants, through the use of poems and songs, lead to deeper and more meaningful findings
- Using a process similar to the Framework Analysis method meant that the analytical stages were driven heavily by the accounts given by the participants
- Framework Analysis method supports the development of strategies which can inform the Destiny stage of AI research

The Findings

Care Home Managers

Appreciative interviews were undertaken with 4 care home managers (staff who have managerial responsibility for the care home). Length of time in the role ranged from 3 months to 18 years and the managers had varied experience prior to entering

their current role which included mental health nursing, community nursing and nursing in the private sector. All of the managers talked passionately about their roles in leading care for the older person even though at times, they articulated some challenges related to education and development.

The following themes emerged from the data:

Discovery

Dreaming

The care home philosophy

Continuing Professional Development

Support for the manager

Student nurses and mentorship

Existing education and development

Permanent Staff Numbers

Being viewed as a speciality

Discovery

The Home Environment and Philosophy

Respondents described the importance of the home environment when considering effective support, education and development. In the following excerpts the importance of a nurturing environment and an explicit philosophy was discussed and the manager was central to these factors.

The first excerpt provides an example the manager supporting a carer through the experience of ringing a GP to discuss a resident's care:

So we'll coach them through. You are going to ring the GP about this and the GP is going to say this back to you. So if the GP says this, you say this back to them. If you get stuck, put them on hold and I'll be there, but you need to make that call. I don't need to, because I don't need the practice, you do. And we will literally hold people's hands and then they will get to the point where they can go and do that and they will come back and "I did it!"...and that is fabulous to be able to see people. But we do push hard... (Manager 1)

The respondent continued by explaining the philosophy of the home, which was one of growth and development, rather than sticking to routines:

The home philosophy is that 'we can' and if somebody would say to my staff 'you can't' I'd expect them to say, 'who says and why?' And I think that is really important because the reason that we are here is to advocate for, to provide good care for our residents and make it the best...it is really important that we don't just follow the routine...it has got to be right for the individual...it's not easy, it's not always workable, but we'll have a go (Manager 1)

Developing an environment which is motivational, positive and happy was described in the following excerpt, not only to encourage staff but to support the residents:

I do like to work in a positive environment. I do like to hear laughter going on...I do like to have, to make sure the residents are smiling, residents are happy. If I could put any kind of motto above the door it would be, 'This is not the end', because if I was to be perfectly honest with you, people come to care homes knowing that this is probably going to be the last place they're ever going to live (Manager 4)

The respondent went on to articulate a fundamental philosophy underpinning the care in the home and the environment they would like to promote:

It's, I hate to be so clichéd but it's that whole thing about how do I want to be treated?...I don't, but living in a care home doesn't bother me provided I live in a care home like this one. It wouldn't bother me living in this care home. I think if any member of staff actually thinks, I'd hate to live in this care home, either change it or leave (Manager 4)

The theme of a supportive environment was continued by the next respondent, who described the need to support staff so that they could carry out their role effectively.

This extended to support and care at a personal level:

...if you have a number of deaths, the staff need support as well, so it's not just about education, it is about knowing the home, knowing your residents and knowing your staff and being able to support them through that...there aren't many things going on in my staff's lives outside of work that I am not aware of, and that's because they come in and offload, they have the opportunity, my office is opposite the front door (Manager 2)

The next excerpt outlines the need for the manager to be approachable and available for staff:

...people may say, 'Oh, I am not asking her, she's the manager'. Staff (in the home) would say, 'Don't be stupid! Of course you can go and ask her, of course you can go and talk to her about it, that's what she's there for' (Manager 1)

The next respondent suggests the need to be visible, approachable and 'present' as a manager in the care home environment:

You have to be present. I think as a home manager you've got to be present. You've got to be in the home. The staff, you know, they know when I'm here, I'm *here*. You know I will be walking around. I will be observing. You know, I will be interacting and engaging with residents and with staff. They know that there are issues, you know, that when issues come up they can come to my door (Manager 4)

Articulation of the need to care for staff both professionally and personally was stated in this next excerpt, which linked the organisational values to staff support on the ground level:

As an organisation our main values are privacy, dignity and to maintain residents independence and we do the same thing for our staff. We dignify them, we value them...if they don't do good work, we can't run a good home. So we value everybody personally and we have counselling support and support when they have any other crisis, we give special leave and we support in a lot of areas, not only training...if they have a crisis situation we adapt the rota to fulfil their family needs...we have got a staff survey every year, so they get their voice heard centrally... (Manager 3)

Manager Support

In addition to care for staff, some managers described how working in a supportive home environment had led to their own development and ultimate promotion. The ethos of the home environment seemed central to this process:

Another reason I am still here, is because this is a good organisation to work and grow up in. The education and the support and the people above us giving the support is really good, and this home, I am the 5th manager who

started as a carer...so our company really is passionate to educate and support people to promote...so I know what are their (the company) values, what is their ethos and what they are expecting. If you are bringing another manager from outside, sometimes it takes time to bring that over (Manager 3)

In the next excerpt the potential to develop from carer to manager was made explicit, based on the supportive nature of the home environment:

...she came to me as a care assistant. She then became a senior carer, unit manager and then was borrowed by another home in the business because they had a home that needed some help and she then went on to be a deputy manager in the home she was working...and then she was developed to peripatetic manager and went around the country assisting other homes. Now she is back running and managing a nursing home...so within 5 years she was running her own nursing home. I think that's because we push people from behind and we'll say, we are there to catch you, but I will help people realise their potential (Manager 1)

The next manager described the type of support that could be accessed for their own education and development:

...we have a one-to-one with our line manager so we can express our concerns and at the same time they can express discuss our performance. Then we have good training and we have in-house trainers...those trainers bring more meaningful training rather than outside ones...I am passionate to learn...when I was a clinical nurse manager, I needed to guide my nurses and I needed to support my care staff and the families. So I thought I had better learn more about dementia. So I did my degree in dementia studies externally...the company gave me support for that and they paid for my course also (Manager 3)

The respondent continued to articulate the particular support that had been required following their recent promotion to the managerial role:

When I got my promotion, somebody from finance came and spent the day with me to go through all of the finance reporting and that is very meaningful, individual help for me to learn. So I am more confident now, you know, how to set up the budget and make sure the home is running and we meet the criteria... (Manager 3)

For the following respondent, managing financial issues was a challenge and they had identified company support for this as being lacking:

To be honest with you, I think if there's anywhere where there's a bit of a cleft, I think it's there....I'm not used to managing budgets of the size that I'm managing...I still feel a little bit in the dark about it, to be honest with you. It's like a bit of, its black magic to me, to be honest...So it's, that does challenge me. So you know, and I have been asking for support with that. So I think if there's anywhere where they need to do some development, it might be along those lines (Manager 4)

Having a network of support was viewed as helpful, as was regular manager meetings, as they are working in what potentially might be viewed as an isolated role:

We have a managers meeting every month and we help other managers. So, if there is something, we can just pick up the phone and say could you just tell me (how to do this)...you know it is great to ring any home and they are happy to help you...we are looking at how we can go from good to great, our company is now looking for that. I got a good CQC report, my aim in the next inspection is to go to outstanding and we have to produce something in the managers meeting, what new thing we could invent or what we could practice. It is really good...sometimes we don't think out of the box and if I have a problem, someone can say, oh I sorted that one...so it saves time rather than invent the wheel again (Manager 3)

Not all managers viewed meetings so positively and felt like they were being bound by bureaucracy and increasing pressure, which was taking them away from the clinical aspects of the role:

Well on reflection currently I feel pressured, under a lot of pressure because of time constraints, I do a ten hour day generally. The time element is to do with me being able to spend more time with the staff, with going out on the floor and having some of the bureaucracy if you like pulled back.... they (the care home company) are going to – I hope – stop all these unnecessary meetings that we have, because we go to one in January, regional, and we go to another one in February, regional, then we are going to a divisional... Why? We discuss the same things at every meeting... I have lost, I am losing touch, I've lost touch sometimes with the floor, and that is my time. Like my job, my role has changed enormously in the past five or six years (Manager 2)

Existing Education and Development

The following managers gave examples of effective educational practice ongoing in the homes. A lot of the training and education was described as mandatory including falls awareness and fire training although some was more specific to the staff role.

The following excerpt is an example of bespoke education facilitated for a member of staff who had a particular developmental need in the area of dementia care:

But there was one nurse who struggled with some aspects of Dementia care, so I booked her in with the local xxx one day course, and just said do this course and see if that helps. You know, perhaps a bit of knowledge might help. What that did was, it ignited her. You know she did that course and it was, that was brilliant, there was loads I didn't know, that was really exciting. She wanted to do more training. So we then linked her in with, because there was further training in that, sort of offered through the local Clinical Commissioning Group. There's further training that's done through the local County Council, you know. We would be, I'd be happy to support if she wanted to do university training, you know to do a module or something at university (Manager 4)

A lot of training was being delivered online and this had been met with a mixed reception by the managers with the following respondent suggesting alternative ways of delivery:

I am not a believer in computer training. I hate it because, and I can do it myself, go and sit at a computer and tick the boxes, turn the computer off and think, what was that about again? I personally don't learn on a 'ticky box' system. If you sit me down, talk to me or give me something to read, I appreciate much more what it is I am supposed to be looking at, and to me, one to one or within the working environment is the way we should be going... would it be better saying to somebody on, I don't know, health and safety, set them up with some hazards, put the hazards in place and see what happens, make it more practical, make it more of a situation because you remember those things. I have done a lot of training in the home...I always make it so that they have get on the floor, they have to go and think about it, we have to move people, who do you move, where do you move them, what are you going to do with them. It has to be interactive, they have to learn from it... (Manager 2)

The following respondent had had a change of heart about e-learning and had begun to see the pedagogical merits of an online method of education:

I must admit when e-learning came in I wasn't really an advocate for it. I've been convinced otherwise. I can see the benefits because in the classroom situation you have always got the noisy one...and you've always got the person sat at the back that is quiet and doesn't speak out and too frightened to ask a question, so they never get to know the answer. Whereas online, you can pause it, you can go and find out what the answer is and then come back to it...if nothing else I have learned that I was wrong about online training because it helps (Manager 1)

A new online system had proved helpful as a means of mentor preparation as described by the following respondent:

We do have access now through the new online system which has only just been launched, but we have access now, so mentors can now go online to do some modules online, if they wish to do some online training, which they can now access, which is brilliant, which I think is really good (Manager 4)

Role Modelling

Some managers gave examples of times when they had acted as role models, often unconsciously, as a means of demonstrating effective practice. This had an effect on junior members of staff who in the next excerpt had taken good practice forward in a new role, emulating the behaviour of the manager:

I see her regularly and it's a lovely complement but she says I am like a parrot on her shoulder. She said that when I hit a situation I think, "What would xxxx do", she said, "and you are like a little parrot on my shoulder and I hear this voice". She said, "You talk me through whatever it is even if you're not there" And it's lovely to know that she has soaked up all of this stuff and taken it away with her (Manager 1)

In the following excerpt, the manager describes role modelling as a way of indicating to new members of staff, the behaviour expected in the home:

I think what the staff see when they see me interacting with residents and interacting with health professionals is, they'll see somebody who will be straightforward, polite, who will have the difficult conversations and be prepared to have those difficult conversations with individuals. I think what that does, is that gives them the permission to do the same. You know, so I try to set a good example amongst the staff group. We have senior nurses, or senior leaders, in each unit... they likewise will have those difficult conversations and sit down with people and role model. And so the other nurses then will then see, this is how I'm expected to behave (Manager 4)

Buddying

For some managers, the process of buddying new people up with more experienced staff was viewed as an effective way to induct them into the home and associated culture. This was positive for the new member of staff and also had a positive effect on resident care:

We ease them into the processes and into the culture here and then once we are confident and they are confident, we can move them up to the next level and get them buddied up with somebody for the next part of their development...I'd be doing my residents a disservice by allowing staff to go (to a particular area in the home) untrained but also doing the staff a disservice because they need to know and be confident in what they are doing before they can deliver the care (Manager 1)

...they get a buddy system, the care assistants when they first start, and the buddy is, I've got two people I use specifically as buddies who I trust implicitly with the care and the way that they work, they are good examples for anybody new coming in and they are aware of how the induction programme works. When we have new nurses (qualified) coming in they are again with a nurse for three weeks, so have that ongoing relationship building up before we let them loose on their own (Manager 2)

Normally, for any new staff, we allocate one person as a buddy. We try to work with them for the first two or three days so if they have any doubts, they will go and ask that person...if you build a relationship with one person, it makes it easier. So, domiciliary staff to top level, they will get a buddy (Manager 3)

For some new staff, despite the manager's best efforts, close supervision and lengthy induction is still insufficient, leading to difficult managerial decisions on a personal level, but made in the best interests of the home and residents:

Sometimes it doesn't work. It hasn't recently, and I still feel as if I, not as if I failed, but I know I gave as much as I could and I know I did as much as I could, but I feel as if it wasn't enough. I don't know how much more I could have done, I did five weeks induction with the Nurse, despite having two meetings and identifying areas that I had concerns about, xxx still wasn't able to make the grade, and still in those same areas didn't improve, and I had to say I'm sorry but the Nurse Manager part of me knows I did the right thing, I couldn't have continued, but I think the personal side of me is thinking this person is possibly the main breadwinner, I've now dismissed xxx, where does xxx go from here, and that is the different side of me (Manager 2)

Dreaming

Continuing Professional Development (CPD)

In terms of articulating hopes for the future, respondents were asked to envisage a miracle had occurred and this meant that they could have anything they wanted in terms of education and development. Three managers focused solely on professional development for staff at all levels:

I'd want to be able to develop my staff teams skills in a better way...so for instance I would like my nurses to be able to access training or development so that they could be the tissue viability specialist or end of life nurse, or, because I think one of the things that is limiting...is that although you can develop to become a manager...there's less specialism within the nursing practice and I think some of them miss that (Manager 1)

For the following respondent, affording staff time to reflect and engage in experiential learning was viewed as beneficial, especially when considering the emotional nature of the role:

Maybe before the end of the shift or sometime during the shift, to do some reflection themselves on, not every day, most of them work 3 days a week, but maybe once in that three day session to sit down and say have we done something well today, or even, this upset me today, did it upset anybody else,

to talk about issues that they have that maybe they won't come to me with or maybe they won't go to a qualified with, but because they are busy on the floor, because they are working on the floor, they don't get to discuss it. I think it would be nice if we could afford them that luxury, and that could encompass both education and training, because out of it may come a training need that needs to be addressed, but on the education side they are sharing experience, sharing practice hopefully, but also dealing with emotion which is important (Manager 2)

There were clear barriers to continuing professional development for qualified staff which were related to resources:

Staff would need to be able to go and train and be able to update, and that takes resources away for the business because who else will do their role while they are away? And it would cost. I would also impact on continuity because if they are away a lot they are not delivering care to the people they are employed to deliver care to...so it would have an impact...because there are not enough nurses...I have explored the nurse practitioner and nurse prescriber, and it is literally impossible because of the amount of time they have to spend doing the training and they also need a consultant prescriber to sign them off and work alongside them as a mentor and they (CCG) have just pulled our last consultant 2 weekly visits because of costs... (Manager 1)

In the following excerpt, the manager envisages a long term educational pathway for development of staff, which would involve supporting them through different levels of education which might need to be delivered externally:

If they come to work as a carer and want to progress, we could give them the opportunity...for example, go to college and study health and social care. Until that time we can support and mentor them...it is a benefit for them as well as us because if someone comes with that passion and they want to learn, they are definitely going to deliver quality of care for our residents...so it is a win-win for everybody... (Manager 3)

The following respondent suggests the need to support and develop staff who are already keen and motivated, to go further with their career:

... I think a lot of it has to do with the individual and you as a person, you have to want to be here, and if you want to be here, you are interested, you want to learn, you want to pick up on what people are saying to you, you want to look after the person... I think it is acknowledging these people, the people who really do want to be here, who really do want to take on board everything that has been said and developing that person as a care assistant, as an individual, and taking it further (Manager 2)

In terms of costs, outlay to pay for education would be offset by the amount that is spent on recruitment and agency fees, involving longer term thinking on the part of the care home company:

You know a lot of the companies are spending thousands of pounds to recruit people and pay for agency. If they put that money, yes, they are not going to get the outcome immediately, but long term, if you recruit one young person who wants to grow up to be a nurse. When they do health and social care for 2 years, you've got good care staff for 2 years, so you retain your staff, quality is good and we support them also (Manager 3)

Student Nurses and Mentorship

Only one of the homes in the study were allocated student nurses although all of the other homes were interested in welcoming students to this setting. In the workshop discussions, some carers highlighted the fact that students would require support and this would be time consuming and potentially problematic in an environment which was short staffed. However they acknowledged that students through their learning could share the workload, viewing them perhaps more as a pair of hands rather than a supernumerary learner. The following excerpts focus on managers views of student nurses and what they can gain from being in the care home environment. For the first two respondents, some of the learning was about dispelling myths about care home nursing:

...sometimes they (students) don't understand or have a bad impression about elderly care...they can't learn anything or they can't grow. That is really

a myth because when you come and work as a nurse in a care home, you need to be a leader, you need to be a friend and when the family come with distress you need to reassure them, support them, you need to supervise and support your staff, you need to write the care plans, communicate with external healthcare professionals. Then if you have any problem with the building you are calling external people. So you are multi skilled and you need to have a special talent...so it gives a good platform for the nursing student to come and experience that and take that message to other people so that maybe in the future the nurses come and work in this environment (Manager 3)

...they (the University) want to bring first year student nurses in to be involved in person centred care which is missing in the hospital... we are now going to be taking third year students on their final year placement, this will be the hope and the idea behind that is to show the third year students that there is more to the care home than old people and wet beds. They will be coming in here and they will be going on their spokes with the Community Matron which I have already organised with the GP practice at the top will have involvement from the local authority, from the Care Managers, so that it is not just, as I say it is not just about old people and wet beds, there is much more to it. My Nurses probably have more autonomy than a Nurse going on to a hospital ward because you have no GPs to fall back on. They have to work on their knowledge, their understanding and gut feeling about a particular resident, so it is completely different (Manager 2)

It's just the same as working in each directorate. You are going to learn something in maternity different to what you are going to learn on kids and orthopaedics and ENT. It's a specialist service in its own right so you learn about relationships and building up trust rather than short term quick fixes...there's no quick fixes it is all long term stuff. It is little individual bits that build up the big picture. I don't believe you get that in the NHS because the provision is so different, it is acute, it is quick, it is turnaround, get people fixed and back out the door again. People don't leave here other than as the last address...it's a specialist service in its own right...I think they are missing out on an opportunity and an experience and that is a shame (Manager 1)

One of the homes provided placements for student nurses and had five mentors working as permanent staff. However the manager expressed frustration at the type of student sent on placement there. Rather than send Adult Branch students, the Placements Team sent Mental Health Branch students, even though the home was designed for general nursing care:

I know they have a good cohort of general nurses so why are the mental health nurses being pushed into care homes constantly? Because that's

all I'm getting. For year after year, I've had nothing but mental health students here, first year mental health students. Because I know they can't find placements for them anywhere else. The exciting placements, yes as would be perceived, you know the hospital ward placements, they go to the general nurses. Why is that? To me that feels, care homes are second class, mental health students are second class. Every mental health student that comes through my door, I will do my best to give a good teaching experience to. And I hope they leave here with really good clinical skills, you know, enhanced clinical skills. I hope they have some really good learning here. But I would really like to start to see more general nursing placements here. And it's starting to feel, after a couple of years, you know we've got five mentors here, university mentors here, and it's starting to feel a little bit like, a) mental health students are second class because we like to give all the exciting placements to the general nurse students; and b) care homes are second class. People aren't going to learn in a care home. Actually, come to my care home because you will (Manager 4)

The manager highlighted that the home would be particularly helpful for a third year student due to the managerial aspects of care home work:

I'd sell that in as much as, you know if you want to learn about staff leadership, I've got 150 staff that need leading. If you want to learn about managing a budget and appropriately staffing units, appropriate according to our budget, I've got £3.2million coming in and out. If you want to learn about how decisions you make would directly affect an individual's care, I've got individuals here with very challenging nursing needs, that we have to make good decisions with, in terms of how much we're spending on that person, the fact that we can't always afford to buy the equipment that perhaps we should have. So how do we use our innovation to make sure that person's needs are met? Well we use that by talking to the local Trusts and charities, we do that by talking to the other care homes, have you got a recliner chair that can take a bariatric individual that I can borrow for a few weeks or borrow for a few months? You know, that's what we do. And if you want to learn how to do those things, to build those relationships, and for me management is a lot about managing relationships, we can offer that, we can do that. So send a third year student nurse to me because I believe they will see far more hands on management here, than they would sat in a hospital ward, where essentially it's about, 'do the rota' (Manager 4)

There was a perception that the university was stereotyping care homes and academic staff did not really understand what care home nursing was like in reality:

I feel angry, disappointed, I think universities need to wake up basically. What I mean by that is, is I wonder how many university placement teams

have actually walked into good care homes recently. They may have gone and visited a relative in a care home, but how many of them have actually gone to visit their placements? How many of them actually had a look around and actually seen what good care home placements are like (Manager 4)

For some managers, changing the view of care home nursing and more widely, perceptions of older people, needed to start much sooner, for example during school years. The following excerpts suggest ways in which younger people could be encouraged to think differently about older people much earlier on in their lives:

So where are we going to end up in 10 years' time and how much work are we putting in now to prevent or encourage people joining this care industry?...we need to send the message and this needs to be part of the school curriculum...people should be aware that this is our duty of care, we need to look after our elderly people...and when they do career development days, we talk about university and college but we need to talk about the healthcare industry also...otherwise in 10 or 20 years' time, we don't know who is going to look after us (Manager 3)

The local primary school, they come in on a once a week basis. And it's really interesting hearing the children coming in and saying things like, "this place doesn't smell" and saying things, you know even, you know year 6s we're talking about, kind of saying this place doesn't smell and leaving saying, "that was really enjoyable". You know so many children don't have contact with older persons, this is the only contact they're going to have. And I'm glad we're making it a positive one for them. We have GCSE students coming in who have to do, have to do an older persons part to their course, you know modularised as part of their course. But when they come here, I want to show them, actually this is how exciting and this is how positive older persons' medicine can be, and caring for older people can be (Manager 4)

The care home was viewed as an excellent environment for this respondent who wanted to encourage even more interdisciplinary learning in the environment, explaining the advantages to the home and residents:

...you know we have student nurses here, why can't we have a student physiotherapist? Why can't we have a student occupational therapist? You know, we have falls here, it would be great to have a physio on site...we could help people improve their walking. It would be great to have an occupational therapist on site, who can make some suggestions and bring some of that, some of their knowledge into this home. So why can't we be offering placements for students along those lines? I think some fluency in terms of,

some better recognition of what actually happens in the care home (Manager 4)

Mentors

Some of the managers were keen to welcome students into their homes although they had no qualified mentors to assess the learners. This problem was rectified in one home by the local university funding the mentorship preparation in order to increase the number of mentors:

We are in the process of identifying staff which is hard because we are limited on permanent staff numbers because of the issues around recruitment and retention of nurses (Manager 1)

In terms of the nurses who actually did their training while they were here, to become mentors, that's about releasing them to do, go to university...the university funded their training, we funded their time. So you had to pay the staff while they did the training (Manager 4)

Permanent Staff Numbers

Some of the homes employed agency staff on a regular basis as they were unable to attract permanent qualified nurses. Although only 1 of the managers articulated this as problematic it seemed to be a cause of great anxiety based on the concern that the nurse might not attend for the shift and care might be compromised:

I have been running with 2 night vacancies for 2 years. Actually 4 night vacancies for 2 years. So the service that we deliver to a very high standard has been done with 2 agency nurses per night for the last 2 years. So imagine how fabulous we would be if I had my own staff...I get a phone call every night to make sure that I can calm down and I know that my day is finished because my night team have turned up. So my day ends at 8, 5 past 8 and then I can relax...if they don't turn up then my day is not finished and then I have got to contact the agency...potentially it can be 10 o'clock at night or 11 o'clock at night or it can be nobody coming in and then I've got to make a decision about how we are going to best meet our residents' needs. That causes huge amounts of anxiety (Manager 1)

Being viewed as a speciality

Two of the managers were frustrated that care of the older person was not viewed as a speciality with equal needs to others and this had implications for care delivery:

We are the poor relation and Cinderella service as far as the CCG is concerned. I think the phrase that keeps coming to mind is that I am fed up of being 'done to' instead of 'working with'. Every single document I read talks about working in consultation with and working in partnership with, but in reality we are 'done to' and I am fed up with it to be honest (Manager 1)

The negative perception of care home nursing is articulated in the following excerpt by a manager who admitted that at times feels 'challenged' to tell people about their role. Rather than being viewed as a speciality, care home nursing is perceived as somewhere to go when nurses are unable to get hospital based work:

You know it's, you feel, sorry, I feel, at times I feel challenged telling people that I work in a care home...You know some people will say to me, you know, oh so where do you work? I work in a care home. You can almost see it on their face sometimes, oh right. And it's kind of switching off, oh right so a failed nurse who is working in this care home because they couldn't get a job, couldn't get a proper job in a hospital somewhere. So I tell people, do you know what, we're part of a national project, we're one of five homes that were chosen to be part of a national care home project because what we do, we do exceptionally well (Manager 4)

This manager continued to describe reasons why some members of society do not view older people as important or having a contribution. This has an effect on recruitment of staff to the setting:

I think some of it is ignorance. I think certainly disrespect. And I think the trouble is for some of the population, when they look at older people, they're kind of reminded of their own morbidity and so they don't want to be reminded of that. They don't want to have that thought of when they're going to be old. I

think that challenges people and I think they don't want to look at it (Manager 4)

Summary: Care Home Managers

All of the managers in the sample were passionate about their roles and the need for transformational leadership. Through their narratives they described the need for a nurturing and supportive approach and the need to role model good practice.

Working in these ways was viewed as beneficial to staff development. A clear frustration for some was the lack of investment in care home nursing and the view by others, that the work was second class, and not seen as a speciality in its own right.

- A supportive home environment and positive philosophy is important for staff development to occur
- There are multiple educative methods which work well for staff in the homes including e-learning, role modelling and coaching
- CPD for staff was viewed as a priority by the managers although for some this was made impossible due to resource constraints
- All of the managers wanted to welcome student nurses into their homes as a hub placement area. However this was made difficult due to the lack of mentors or lack of understanding on the part of the university, of what the home could offer
- Most of the homes relied on agency staff and having a permanent staff base was viewed as important for quality care delivery
- The managers wanted to raise the profile of older peoples nursing and for others to view it as a speciality

Qualified Staff

Appreciative interviews were undertaken with 6 qualified staff (Registered General Nurses) who had experience in various roles before being employed in the care home setting, with the exception of one, who had chosen care home nursing as a career choice upon qualification. This was based on positive experiences in a care home during her undergraduate nurse education. One staff member worked night shifts and the rest were employed on days, with one nurse acting as a Unit Manager. They spoke passionately about their roles with many describing the person centred nature of care home work as being a major benefit when compared to hospital based care.

Themes

The following themes emerged from the data:

Discovery

Person Centred Care

Manager Support

Continuing Professional Development

Roles in the education of other staff

Leadership

Dreaming

Continuing Professional Development

Future proofing

Student Nurses

Staff/Resident Ratio

Discovery

Person Centred Care

Some of the respondents in the sample valued care home nursing due to the long-term relationships, which could be built not only with residents, but with their families. This led to a more person centred care ethos which for some, was a great contrast to hospital based nursing. The following respondent chose to work in a care home setting based on the person centred nature of the work, rather than in the acute setting, where practice was described as a 'conveyer belt':

... I left (the acute setting) because I felt the patients weren't getting treated as an individual, they were getting treated on a conveyer belt system and you were getting a patient of say 24 and patient of 84 having the same plan of care and that an impossible task. Its condition orientated not patient orientated... you are going to get used to them on a personal basis (in the care home) and they can get used to you on a personal basis and I think you can get more out of a resident and hopefully the resident can run things past me... this is going to be their last place and I treat it as xxxx (name of the care home company) own the building, xxx pay my salary but I'm coming into their home to look after them, it's not a clinical area (RN 2)

The ability to develop relationships not only with residents, but with families, was viewed as important and satisfying for the following respondents:

... there is a lot of humour in this work, there's a lot of connections with families and I particularly feel it's important to support them. I have had a few experiences where they have opened up to me... we get people who are admitted and the family have gone through this journey, its financial, it's their emotions and one big thing is to support families and I get a lot of satisfaction from that... it's a different kind of nursing in a care home (RN 3)

... in a hospital you look after them only when they are in there. You do the observations, ask the doctor to see them, to do the doctor's rounds and check their, it's only basic information... in the care home, you are, it's like studying how this person is. It's knowing this person because if you don't know this individual, you won't be able to look after him or her... and also the family, they have to be involved because they know better than we do. So by talking to the family and the resident, they can give us information that will help us. It lets us

develop a professional relationship. Sometimes it can exceed, sometimes you know, because, yes so we are in more close contact with them (RN 6)

The following respondent described the reason they had chosen a career in older person's nursing, which was based on their experiences being placed in a care home as a student nurse. Building relationships with residents was something that could not be experienced in an acute setting:

I think it was just the relationships you could build up, longer term relationships. Although obviously in a placement I was only there for a few months, but to build up those relationships, not people I am just meeting once or maybe twice...I really liked those sort of long term relationships and (the residents) recognising me (RN 4)

Manager Support

For the following respondent, the care home manager was the sole reason for them continuing to work in that particular care home:

Xxx (the manager) is part of the team and that is my only reason for staying here. I said I would stay until xxxx retired.... Xxx is very open, knows the residents, knows everybody by name, knows exactly what is wrong with them, can talk on their level, talk to the carers at their level, is there for support for anything you've got a problem with...the perfect manager (RN 2)

Having an inspirational manager was an important factor for the next respondent in terms of self-development:

I also got sort of the same from the staff as well (good relationships), particularly from the Manager ...somebody who really inspired me...we clicked and she brought out a lot of myself which I hope to think I've taken forward in my nursing (RN, 4)

Being listened to and taken seriously by managers was important for the following respondent in terms of their development:

I value my seniors sitting down with me and listening to my concerns, via appraisal, via regular supervision. I feel I can be open and honest about any concerns I have regarding staff, residents and relatives, promoting the way forward. Improving standards. Looking at individualised care. I feel I'm listened to (RN 5)

Continuing Professional Development (CPD)

The following respondent valued the availability of CPD accessed through the care home and the opportunity to have 6 month appraisals with the deputy manager:

We have regular conversations, documented conversations regarding progress, development etc (with the home manager) and always looking for what else can we do...so that is from an in home point of view. There is also any time we attend company training, the feedback forms are always, well, what else, was it useful, what else, can we build on this, to see if there is obviously a need amongst people regarding that (RN 4)

6 monthly reviews of progress were viewed in a positive way and could act as a documented record and reminder to both manager and nurse about what had been agreed:

I like it. I mean obviously with new starters it happens more frequently while they are finding their feet but it is just nice to know that somebody is listening... I think because it's written down we know it is a formal, legal document then. To actually go, 'Right, you said I could do this', there is no comeuppance on that almost or vice versa, comes to me, it's like actually 'Because you said you were going to do this, have you done it?' So it is quite nice, sometimes I need that little bit of a prompt, that works well with me sometimes (RN 4)

Educating other Staff

The following respondent described the benefits of face to face mentoring of junior staff, using the care home as a classroom for learning, viewed as a more authentic

method, and leading to more learning than that which could be gained by attending training days:

I've got one particular carer I can think of, she says to me all the time, 'Are you fed up of me asking questions all the time?' And I absolutely love her asking questions...because I can come up with the answers, I can tell you why, and she is so interested and it's nice to see that sort of, that positive, that she wants to know, that eagerness...I really like that, what I can give to others, it is not what they can learn on training days, it is actually right here, right now, you know, actually the way that was handled, what can I offer them, what can I feed back to them on that? So I find that very rewarding...I can't see how it can't be a classroom. It may not be a formal desk, sitting down writing, but...you have done that and you know why I did that, because of this, thank you. You have to justify a lot of what you do here, yes, so it is just a working classroom so to speak (RN 4)

The next respondent describes opportunistic education sessions, linked to the needs of the residents, which leads to junior staff being able to take more responsibility and gaining understanding around why certain actions are important, for example, pressure relief:

I quite often do little session if we have got somebody with diabetes, if they are interested they will ask, so I will spend 10 minutes explaining things... they are pleased to have that knowledge aren't they and it just enhances everything, you know, if they have got some understanding... it's like pressure relief.... They look at the bigger picture and... people take some autonomy... you know, the reason why we are doing it rather than just saying that they want turning every 3 hours... so we are creating that learning environment as it is (RN 3)

The following respondent described their role in the home as a trainer for dementia care although at times it was difficult for staff to take part in the modules due to other demands in the home. Nevertheless, visible changes in practice had occurred due to the training delivered:

I am a trainer here and I really enjoy that and I like working with people, I am inspiring people... there's six modules and it's very difficult in this environment because of the nature of the work, so they might do one this month but it might be 2 months' time before they do the next module, which isn't ideal... it's been really valuable and I think it is good of this company that they invest that time... you can see the changes in practice through that training, you can feel it, you can sense it and you can see by the way people interact, it has been valuable (RN 3)

In the next excerpt the need for education is reinforced as a way of promoting person centred care:

... my belief is, people have to be educated, they have to know why they're doing the job, they have to know it's just not task orientated. They have to look at person centred care and you know, I've had good experiences in the past where I have done some training. I've undertaken training with staff and I have seen the results, that they look at more person centred and they stop and they think about what they're doing and the consequences and education is the way forward (RN 5)

In the next excerpt, inspiration to develop as an educator had come from the care home company. Aside from being involved in formal training, the respondent had acted informally to support other staff members both personally and professionally, something that they enjoyed doing:

... they have given me an opportunity to develop in this role and people say I am good at it. I would never have thought but it's this company that's inspired me to do this, I wouldn't have put myself forward in the first place but now I feel very confident to deliver training and quite often our staff come to me and want me to help write letters, or give references... so you know, it's education in a way, its happening all the time, you are supporting other staff whether you look at it like that or not (RN 3)

The respondent was viewed by the home staff as a natural educator and role model to others and could have been in a more senior post but for personal reasons, which had meant they were unable to increase their hours and step up to the 'Deputy' role:

... I have never had much confidence in myself, but it's the feedback I get, when I actually took the post, they wanted me to be the deputy, but for personal reasons... I didn't want to increase my hours... you know people wanted me to do that and they come to me, so obviously I represent that whether I feel it or not... it's how you perceive yourself really isn't it? (RN 3)

Leadership

The importance of leadership was articulated by the following respondents who described being visible, encouraging others, and having the ability to coach staff as important attributes of a leader in the RN role:

I don't like to be the one stuck in the office with the door closed, I hate that, I really don't like that. I don't feel I can support or work with my team if I am not with them. Obviously there are times, you know, but I like to explain to them 'Right I'm doing this', I don't want the whole 'Where have you been?' or 'We haven't seen', you know, I like to be part of the teamwork (RN 4)

... a lot of young girls who have come in particularly one over the last year... really lovely girl, lovely nature, I kept saying, 'You would be an ideal nurse' and she was like, 'Oh, I couldn't do it!' I said, 'I will help you, I will help you generate your reference' anyway, she got in... I feel I would like to inspire other people, there are certain people you see qualities in and it's a shame... there needs somebody to push them to do things (RN 3)

The ability to make autonomous decisions was articulated by the following respondent, in terms of care delivery for residents. This extended to diagnostics and prescribing, giving the example of leading the decision making for a resident with a urine infection:

... even if the doctor doesn't come, it's over the phone... so and so has a urine infection, can you please prescribe some antibiotics. Sometimes I have to say, so and so is allergic to Trimethoprim because I know that would be the first line of treatment so I'd say, they're allergic, so can you please prescribe this, sometimes you'll have to say, so and so only takes medication in liquid form, so you are actually prompting the doctors what to prescribe (RN 1)

The following respondent described the ways in which they role model effective behaviours which include being calm in difficult situations. This has a positive effect on other staff who had noticed this effective style of behaviour:

I hope it doesn't sound like I'm selling myself, but... other students and my colleagues say... when things get so busy, I tend to be like, calm down, you know, with the situation. If you're not calm, if you're panicking, you will make more mistakes. So if you think it over, give yourself time and space to think and sort the problem... we have a few patients who are under palliative care who, you know if you're, they're dying, then you have to be selective what you say. So I've learned so many things about it. So yes, they said I'm calm, I deal with the situation accordingly, and according to the policy as well (RN 6)

Dreaming

Continuing Professional Development

The following respondents were keen to take up further study and could see the benefits to the care home although there were various reasons why they might be unable to access opportunities. For the following respondent, although the CPD would be facilitated, their current personal commitments meant it was difficult to engage with it at the time:

... what I want to do is a degree in palliative care which I've got full support from management for but... it is actually the personal side that is holding me back just at present... (it) is just something over the last sort of seven, eight years that I sort of feel I am really driven towards, I have a huge passion for and doing it I can bring something extra to the home to be able to support others and just obviously be able to work better within my role. I know it is available, it is just me, not ready, not able to take it right at the moment... from the practical side of it, you know, I am reasonably certain that there wouldn't be an issue because we could just tweak shifts and things like that... so I have no problem that it is going to be facilitated (RN 4)

For the next respondent, being a nurse prescriber was a dream although this was not a priority for the home and mentorship education was the priority:

Well my dream course is to be a nurse prescriber and I think many of the homes are doing it because they are prescribing in their own home setting but at the moment, I need to do my mentorship (RN 1)

The next respondent had one dream in mind, which was that of becoming a care home manager. There was acknowledgement that further training would be required although the respondent had not articulated the future dream to the care home manager:

I wish I could be a manager one day. I think it's the management training which I'm still lacking. That's the one missing, I mentioned the management training (in the recent appraisal). I've mentioned that one, but I didn't mention that I wanted to be (a manager), I didn't mention that. I just wanted the management training (RN 6)

When asked what being a care home manager would mean, the respondent articulated the importance and their commitment to the home, going so far as to describe it as their 'first home':

Well I just like managing the home really... I've been working like, sometimes 5, 6 days a week here. This is like my home now. It's not my second home, it's like my first home. Yes. I just like being here and I think, I want everything in place, I want everything done. Just like if you come to work today, sometimes when you go home and think about what you've done, it's like, it's not, something is not complete. So that's why sometimes I always tell my manager, can I come today, can I work today? So I just want everything done (RN 6)

The importance of CPD for all staff in the care home was articulated by the following respondent. Having informed and educated staff was a way to improve care provision for the residents and CPD was something that could be delivered in the home:

...to me, it's always got a bigger impact hasn't it? You know, somebody falls, it's not inevitable that people fall, but there's a high risk, elderly people, fractured femur, cost to the NHS. If you have got the right staff and the

training to observe people...some things are as simple as that... its getting through to people... you know, they are very at risk from this... we can never prevent it, but we can minimise risk and its people having that bit more responsibility and I think that comes from education... (RN 3)

But what I've been looking at is, what my vision is, to have training on the floors, that practical training, with care staff, and it's making them more aware of their role, and the reason why they're actually doing the job... and to get away from task orientation and to look at the broader picture, and to look at person centred care (RN 5)

After further probing about avenues for CPD, one respondent described a need for consultation and partnership working across universities, colleges, communities and the care home companies, whilst acknowledging that the homes were businesses, required to make profit:

... it's got to be a consultation between universities and corporate industries like this, you know... but I have heard it is becoming more of a business now... so I think there is a danger there isn't there? You know, it's working all together for it to happen, it's got to go through universities, local colleges and community... its putting that input in from everybody to make it work I would have thought (RN 3)

University links were considered important by the next respondent as a way of accessing information. The use of the online library was suggested as a worthwhile resource and viewed positively especially when compared to searching the internet, which was not viewed as time efficient:

I think that would be very useful, especially like I said because I work out of hours, because you have got limited resources, but the whole 24 hour care, anything after 5, weekends, nights, you haven't always got somebody you can pick up the phone to and that's a very long night if you are suddenly working, if you are working blind almost... the internet is very good but you do have to spend a lot of time fishing through what's good and what's not so good and you know, it is not very efficient. Sometimes it is not as efficient as it could be (RN 4)

The university was specifically mentioned by the following respondent as something to explore for education and development of staff:

Educating the existing staff, continuous education for the existing staff. From the basic thing, when you come into a care home, what do you see, what do you smell, what do you hear? If you walk on the floor, do you see a resident isolated and sitting on their own, you know. I, person centred care I think is the main key thing. That's what I would love to see, for each individual. I would like it here in the home, okay, but I would also like it maybe via the university, explore what universities have to offer. Because I'm sure there's scope there for further development of the registered nurses, and myself too (RN 5)

The need for in house scenario based education was articulated in the following excerpt, based on the belief that some of the carers did not respond well in a more formal classroom setting:

I would like something in-house. A lot of our carers are scared of the classroom experience and I think if it was in-house we would get more of a response... I have just supported one of the carers through their NVQ level 3 and she has had great difficulty in writing it down and I think I went through that when I did my training. I could go onto a ward and do personal care but then it was coming back and writing it down. I try to do it (teaching in the home) in a friendly manner so they don't feel as though I am lecturing them... because its no good filling them full of 'professional' if they can't take it on board... giving them scenarios so they learn better (RN 2)

In the next excerpt the respondent describes the home's move to e-learning and this was something that was viewed negatively as a means of education:

I don't learn on e-learning.... The carers will come in and try to skip the beginning and do the questions, I can't do that... I just don't think you learn, I think you learn more face to face in a more informal setting than a classroom setting... ticking boxes doesn't learn you anything (RN 2)

For the following respondent there was a clear need to be able to access relevant information as soon as it was required. Described as 'miraculous', an onsite training co-ordinator was viewed as someone who could offer immediate access to learning

and provide answer to support care delivery. This was viewed as particularly important for staff who work on night shifts

... it would be miraculous and actually probably not even viable even regardless of funding and things, I mean we have got training coordinators, people who do in-house training, but if you could have somebody on site like say to have somebody, like sort of a resource room, somebody on-site actually I need to do learning about this and I need to learn about it tomorrow. Okay, that's fine. But that is completely impractical I think, but the fact that we have got it, it is not on-site but because it is in the company, it is almost, it is not the same but it is well on the way to being there and how needs can be identified quickly (RN 4)

When asked what would be the one thing to make a difference to the working life of a qualified nurse on night shifts, the respondent immediately returned to the ability to access information readily:

I think it would actually be physical resources that could be accessed 24 hours a day. You know, just for somebody to have a quick read through, you know, just anything. That would make a difference overnight (RN 4)

Future Proofing

The following respondent describes the need to recruit appropriate staff into care homes and invest in support and education as a means to both attract and then keep staff engaged in the setting and support quality care provision:

There's got to be more investment, which means education, it's got to attract people in for the right reasons. It's no good beating about the bush, I have walked in places where some guy has been a lorry driver and he goes to the Job Centre and it's there (a care home vacancy) and he comes in and it's a bum on a seat isn't it... Not discriminating against people, but we want to attract people in because they want to come in... it wants to be a place people feel like they can grow and they can be supported and companies have to look at staffing levels... they are ticking boxes to say we are staffed... its looking good on paper but its actually delivering that whole thing and having the right mix of staff, the right compassion and its only through education and support we are going to achieve that (RN 3)

The respondent continued to speak passionately about the amount of resources wasted on recruitment of staff who had been unsuitable for work in a care home setting and had lasted very little time in the role. There was a description of the need to invest in existing staff as a means of retaining them in the care home setting. This would be more cost effective than regularly recruiting new staff due to the existing staff leaving due to lack of career and development prospects:

... because in the long run it's got to be worth investing in financially for the bigger picture hasn't it? Like now, we have got this talent here, I think in the past we have paid £3000 to recruit a nurse and she stayed 3 months. I don't think they took anything back to the agency. That's happened a few times and that's money down the drain... it costs about £500 just to recruit someone... because its uniform, CRB checks, induction... so many people come through, 2 weeks and they are gone, all this money is building up, so to me, investing in the people we have got, the people who really want to do it. It would make financial sense wouldn't it... it's not going to be a massive expense is it. It's just somebody to study what we need to facilitate that (RN 3)

Having clear career pathways, and routes which led to other things, not only management, was viewed as an essential means of retaining and motivating staff:

... at the moment in this company the staff can't grow. They can do NVQ 2 and 3 and they could grow to management if they want but there's not many of them. There's not many homes and people don't want to up and move to Timbuctoo so really they are stuck at this, they are here... but there is nowhere else to go... there's a lot of talent we could use there and it's just finding the pathway (RN 3)

Student Nurses

Based on experiences elsewhere, the following respondent describes the benefits of accommodating student nurses in the care home setting:

I really, really enjoyed it and you know sometimes, we, because we are working on a daily basis, some things get routine to us but when you are with

a student you are there with fresh eyes... I learn by teaching... as nurses they should all have exposure to a nursing home... this is an integral part of the healthcare system... so to understand what is personal care and what is person centred care, planning, things like that, you need to have that exposure in a nursing home... people think it is just about getting people to the toilet, people don't understand there are so many other things (RN 1)

The following respondent describes the importance of having students in terms of two way learning:

But I think it's important to have student nurses. It's a good experience for them, plus it's a learning environment and we learn from them and they learn from us (RN 5)

The next respondent highlights the benefits of experiencing positive care home placements during her own undergraduate nurse education:

I started, well when I was doing my nurse training I was offered a placement at a care home...I did my placement, thoroughly enjoyed it and sort of on the back of that I ended up getting some relief hours as a student obviously to sort of fund the extra, to get through university. From that, I built up a really good relationship with the Manager and we actually had several conversations actually, once I'd done my training, would I like to come and work for her as a nurse...Obviously right from the...talking about that with my peers, 'Oooh, you are not going into hospitals? I enjoyed the majority of all my placements within hospitals, I got a lot out of them, I really, really did but it was, I don't know, it just didn't seem quite right for me... (RN 4)

The following respondent describes how undertaking mentor preparation had been a challenge although ultimately had led to positive experiences for them as a nurse.

Mentorship had led to a sense of fulfilment and the ability to pass knowledge on as part of the evolution of nursing:

Oh it's very challenging, after all those years... going to the university, so much writing, so many essays, 2,000 essay and then 500 essay as well. So it was a very big challenge for me, which I managed to survive... It's a cycle, it's evolution. You learn, then after you learn you impart what you learned... all of the students that come here, or I mentored, they said so many good things

about me. So they said... I know you are busy but you still manage to give us time to teach us (RN 6)

Staff/Resident Ratio

For the next respondent describing an ideal world consisted of having fewer residents and more time to spend getting to know them and promoting person centred care:

... if the ratio is much lower, you can spend more time with the residents. I am not a person who likes to do the paperwork and things like that, I would rather have some time with the residents, you know, have a minute to talk to them... this is how you will know what they need. You need to know the normality of the residents to know what is abnormal for them... if you have a larger number of people, which is definitely a difficulty (RN 1)

For this respondent, having too little time meant an inability to complete the work which was very upsetting and led to a feeling of letting the residents down:

I had to do so many things, it was a really, really busy day and there was a lady who needed to have dressings every one to two days... so I had a look... it was the second day... but I didn't have time and then when I went home I Was crying because I felt I hadn't done something I should be doing and it is so stressful and it is not a happy pleasant thing to go home with that feeling. The following morning I came in here early and I did the dressing before I did anything else (RN 1)

Summary: Qualified Staff

An overarching theme in the data from the qualified nurses was the concept of person centred care and the need to promote this in the care home setting. For many this had been the main factor for them entering care home nursing in the first place. Further, the nurses felt they had an obligation to encourage others to adopt person centred practice and to educate carers about the reasons why care was delivered in a certain way. The qualified nurses valued support from the senior staff

and there was a desire for ongoing development both in terms of CPD and access to information to support decision making, care planning and delivery.

- The qualified staff valued the person centred nature of care home nursing and the long term relationships, which could be built with the residents and families
- Some staff valued the CPD opportunities available through the care home although felt there needed to be more investment in and developmental opportunities for staff, which might increase retention
- Having a supportive manager was viewed as important to some staff
- Student nurses were viewed as a positive addition to the care home setting
- Qualified staff valued the opportunity to educate and support others
- Links to the university and other agencies was viewed as beneficial to the qualified staff, to support development of themselves and other staff members

Carers

Appreciative interviews were undertaken with 5 carers. All of the respondents had experience of care work, and length of time in the role ranged from 2 – 13 years. The carers talked enthusiastically about their roles and could identify a lot of effective practice relating to education and development. However the carers were less able to suggest ways in which their development could be enhanced. Each carer interviewed described a different issue and there seemed little consensus among the respondents. However the issues raised in the individual interviews were supported in the group sessions and many of the themes were revisited without prompting, and developed into the Provocative Propositions (see Summary of Workshop Data). Further, many of these issues were raised in the literature sourced as part of the Scoping Study.

Themes

Discovery

Passion and commitment to care

Education and Development

Opportunities

Formal Educational Methods

Dreaming

Finance

Access to Information

Staff

Flexibility

Discovery

Passion and commitment to care

Underpinning all of the carer interview data was a sense of passion and commitment to work with older people and a desire to share these values with other staff, for example, novice and junior carers. In some cases, staff became very emotional during the interviews, when trying to convey their positive feelings for this work:

I am going to start to cry because like it is something I am so passionate about, I want to wave a magic wand and I want everybody to have the same kind of, oh God. Sorry. (became tearful) (Carer 2)

Staff spoke passionately about their carer roles and seemed proud to provide quality care for the residents. For some, the ability to support residents to live their lives as they did before admittance to the home was a priority:

I think one of the best things is the fact that we're allowing people to continue their lives as best is possible. Especially with the dementia care that we provide here, I do think that we are head and shoulders above some others. We are very person-centred. We've had people, family members, cry when they came and their parents weren't here, not because their parent wasn't here, because they thought this is where the buck stopped, this is it, my mum will never come out of this place again and yet she was out, active in the community, and it is those kind of things that make the job worthwhile (Carer 1)

They have lived all of their lives, they have worked all their lives and ended up in a care home, and how many of them must feel abandoned and all the rest of it. Why can we not make their life a little bit better, or the best that we can, you know (Carer 2)

Education and Development Opportunities

The carers reported that there were many training opportunities available to them, often supplied 'in house' and having undertaken the training, they were then in a position to formally disseminate their knowledge to other carers. However in the following extract, there is a suggestion that the home based training will be

discontinued in future, and supplied by external divisional staff, meaning a loss of opportunity for home based workers to develop their teaching skills:

There is quite a lot of training on offer, I mean there is the mandatory training like fire training, health and safety, infection control, those sorts of things, but at the minute I have just done some person centred care training with the hope that I can deliver that training to other people, but because the company has had some big changes, I think they are doing away with home based trainers and having divisional trainers. So, there will be people coming from within the company to do training. My manager said if I wanted to, between now and the end of the year, before all these things come into place, I could deliver some of that training because I think it is really important (Carer 2)

In the following excerpt, the respondent reported an opportunity to become a 'Care Leader', someone who has a greater role in assisting the qualified members of staff. However apart from one carer working on days, nobody had taken advantage of this opportunity and the respondent did not know what might be involved in terms of preparation:

The home does do a lot of courses. Obviously there are normal courses and mandatory courses and things like that. They do, funnily enough, [we were] talking about this, actually. They did, before, something about - something about becoming a care leader and things like that. But it was mainly like who wants to do it? Who wants to do it? And nobody. At least nobody at night, at least... I have no idea, (what training was involved) because nobody went on it. (Laughter) So we don't know. At least at night. I know during the day one girl, at least, that I know of. But I don't know... That may be something for the future, if they manage to get somebody at night. Like, if it's open for people at night (Carer 4)

Similarly, the carer in the next extract had applied to be a care practitioner although the application seemed to have been lost and nothing had been discussed for five months. The role would mean working more closely with the qualified staff, a similar role to that of Care Leader. On site mentorship would be required and attendance at a number of workshops:

So I will be working alongside a nurse and doing some of the kind of more clinical work, so it might be that wound assessment and dressings, catheter care, peg care, that sort of stuff but I think it was May or something I put my application in. My manager is busy trying to chase it up because I haven't heard a thing back...I don't know (where the workshops would take place) because there's, I have done a couple of bits of work that was given to us by the learning development person, on tissue viability and observations, doing a couple of bits on that but haven't heard anything back, she hasn't even been back to kind of check it or anything, but you go to actual workshops and you have got to have an on-site mentor, so none of that has been discussed yet, so I just don't know where I am with it at the minute, but my manager is in the process of chasing it all up (Carer 2)

The following respondent described the value of education and development in terms of their own ability to communicate with residents:

I think I have improved big time with my communication, the way I communicate to my residents, their family members. It used to be, I used to get challenged, the way maybe I would be... my communication has really changed during my, all this training I have been going through (Carer 5)

Experiential Learning

Completion of courses was viewed as only one way to gain knowledge and skills to support effective care of the older person. The following excerpts highlight the importance of experiential learning. The respondent in the next excerpt had been in the carer role for 13 years and discussed the importance of experiential knowledge:

I think a lot of dementia care comes from experience...there's only so much you can learn from a text book. Each person presents completely differently and you've got to be open, to be pliable, to be adjustable to each situation, each person and how they're going to react with you. We have the Dementia Awareness training that goes on but a lot of it comes from imparting personal knowledge as well, like the more experienced carers helping the new employees learn. They are not always aware of all the different distraction techniques that can help certain individuals, what works best with individual residents. So the personal knowledge of individuals and passing that on is one of the main things that you can do. Yes you can learn so much from a text book but each person's life experiences affects how they're going to present in the future I feel. And getting to know each person as best as possible on a personal level helps with the care that you can provide (Carer 1)

One respondent was facilitated in their ongoing reflection on practice, through 'Supervisions'. Supervisions were held with a more senior member of staff on a 6 monthly basis with a focus on growth and development. This opportunity was valued, not only as a means of reflecting on practice but as a time to feel appreciated:

It's on a one-to-one basis, and they review our performance, but I have to say it's mainly positive...You're doing this wrong – no, it's not like that. It's like maybe there's some room for improvement here? That's it. So yes – they are good because then it shows you that they are paying attention to what you're doing. So, good...the work doesn't go unnoticed, does it? So it's like they know that I'm doing something good, doing my work right. So, yes – it makes you feel good because they value your work (Carer 4)

The need to feel appreciated and valued for their contribution to care was a theme which was identified strongly by carers during all of the workshop sessions and informed the many of the provocative propositions agreed and generated by the groups.

Role Models

It was evident throughout the data that carers often acted as role models to more junior staff and that they themselves also benefited from positive role models.

However, lack of time might prohibit the passing on of knowledge to others. In the following example a more senior carer had attempted to pass on a holistic ethos to promote less task orientated care provision:

I think, I mean I have always thought person centred care is really important, and I think that if, there is not always enough time to do the things that you could like to do. Do you know what I mean? There is not always enough time to spend, quality time with the residents, and I think staffing levels are really important. Like I say, it is normally four carers and a nurse upstairs, sometimes we are with three carers and that makes things, I mean it is difficult with four carers and nurse but it is even more difficult when you are running with one member of staff down, but I just, what I would like to see is everybody or you

know everybody be as enthusiastic of things as I am and be able to deliver that person centred and treat everybody as individuals, and not be so task orientated, do you know what I mean? But it is kind of getting that over to some people anyway (Carer 2)

The following excerpt describes how the carer had benefited from the experience of other staff and then she too had supported and encouraged someone else. She particularly enjoyed the style of teaching adopted by the senior worker:

I think my very first, not day, night – my very first night in this place, obviously you are very- well, I was very nervous and all that – new job and everything. And after a gap, you know, to have children...and coming here I was put with a lady – that was the manual handling trainer at that time. And she was really good but she, it wasn't sort of like, it didn't feel like she was telling me what to do. It was mainly doing it, how you do it...It felt really nice the way she was approaching the whole process. And then, so, obviously, it sunk in quite quickly, and I could remember, oh yes, that's the way to do it. Well, that was my first night. Then some other time I was paired up with another girl, it was her first night as well. But I was showing her what to do around the home, the routine, and she was really receptive. It was like the two sides of the story: I was first learning and then I was teaching someone a little bit. So, those two nights were quite good, I think (Carer 4)

When asked about her ability and enjoyment of teaching she continued to focus on the style of facilitation and the satisfaction gained when she was able to influence someone else's caring practice:

It's, I don't know how to describe it because I don't think of it as I'm telling them or teaching them; I'm sort of like maybe reminding them. Because I know they know it; they know it. It's just mainly, I don't know, showing them more than telling them, I like to call it. (Laughter) and yes, it feels great. It feels great. Because you know, you know when you're listened to, don't you? And so it's sinking in. You can tell that it's sinking in by the way they do things afterwards. So yes it felt great and I loved it (Carer 4)

Her facilitation style had been very much influenced by her exposure to a positive role model on her very first night shift and this was important as she had been

identified as the Moving and Handling Trainer for the home, and would need to support others in developing skills in this aspect of practice:

Well, I didn't know it at the time but now, talking to you now, actually, I just realised I sort of like want to implement the same thing that the last lady had with me – that first night. Making it not sort of like school type teacher student; more like, hmm, fun if you want to call it. Not obviously not 'fun-fun' but, yes, sort of like more relaxed and more- more on a one-to-one informal way to teach someone how to do things. Because I think it's- If we're on the same level, we can always just grow from there. I mean, I don't think I would like someone telling me do (it like) this, do it like that, like that, you're not doing it right. That's the thing. Focusing on the positive as well. Because if you're always telling someone, 'you're not doing it right, you're doing it wrong, do it like this, do it like that', that just doesn't feel good. It brings their morale down as well, I think. (Carer 4)

The importance of an encouraging style of facilitation was described in the following excerpt:

I think it is really important because if you feel that somebody is supporting you, because if you feel alone you feel like oh the world is against me, but if somebody is encouraging you...I mean try to learn these new things, you feel like okay somebody is trusting me or somebody is believing in me. Which is, I think that is the best, like encouragement from other people which I think it helps you as well to grow (Carer 3)

Many experienced carers had a substantial role in mentoring less experienced staff members in some important aspects of practice:

Yes like if we have got new staff in you would do like it is a three day induction, and that person would shadow you and you would share your knowledge and skills with them and hopefully, hopefully they would carry those skills forward. I guess it is kind of mentoring but there is that sort of side to it and then there is kind of like, I don't know, kind of like the younger carers sharing your knowledge of, I am going back to dementia again because they don't have an understanding of it, so say if a lady said 'Eee I must get home because I have got to make my dad's tea' and she's 96 years old, somebody (a younger carer) might say to her 'Ah don't be silly, you are 96 years old, how old do you think your dad would be?' Well you wouldn't do that because you have got to live in their reality, in their little bubble, it is about distracting people and just explaining to the younger carers...explaining to them, you know, that this is what happens when you say that because for all her dad died all those years ago, to her you

are telling her for the first time that her dad is dead. I always try and give a scenario where they put themselves in their shoes, how would that feel for you? (Carer 2)

I always try to remember what it was like being a new starter and all the questions that I used to have and I try and impart the knowledge on the job so to speak. I will explain to people why we do things, I'll explain to people you know the dangers of certain activities, why we risk assess and all about the positive risk taking that we take within the building. We take a risk walking across the road don't we... the lady that went out (a resident who had gone on a planned visit out of the home). Her daughter thought it might be too dangerous for her but with the right level of risk assessment, the right amount of care provided, you know you can take positive risks to enjoy things (Carer 1)

The following excerpt details the role of a more experienced carer in encouraging and supporting a less experienced staff member, who was lacking in confidence:

...because we have got one colleague that is really interested in nursing, it's just that she's lacking in confidence and she thinks she cannot make it. But telling her your experience, I mean you go to school with no knowledge about things and you feel afraid of doing that course but in the end you will get it. I mean you will feel satisfied because you learn bit by bit, you cannot just go on one course and learn everything quick. That's why I am telling it to her like encouraging her that this is what nursing, it is not about, oh it is not about you know doing your job, you have to love your job, you have to put your heart in it, it is not just about praying because she's like oh I'm so thick, I don't know this. I said you are a nice person, I can see that you love to do it, it's just that you are lacking of, you just need a bit of pushing. So I think for me that is an achievement for me because I am trying to encourage somebody who is willing to learn (Carer 3)

The importance of effective leadership from the home manager was highlighted in the following excerpt in terms of supporting staff development:

...xxxx leads from the front as far as the team are concerned. If we want to do something and somebody says no, well xxxx asks the question, why, what is your rationale behind the no, what can we do to make things work, what can we do to make things happen... (Carer 1)

Preferred Educational Methods

The following excerpts reveal the method of training and education preferred by carers in this study. An in house face to face dementia awareness programme had been delivered by staff from the company and was well received:

I did like the dementia awareness...if you come into care it is important that you have an understanding of the people that you are looking after and to be able to share like your knowledge and skills is a good thing...my experience before that, I'd worked in care for a lot of years but I've worked with people with learning disabilities, I've done mental health, worked with people with mental health problems, so there is a lot of stuff in there that sometimes needs dragging out...because it is something that I am passionate about, I got some information, like even I wasn't aware of – do you know what I mean? So it was very kind of, it was knowledgeable, it was, there was a lot of content in it and it was well delivered, so it was, I really enjoyed it and like I say because it is something that I'm interested in anyway and I think any sort of training, if it is well delivered and it is something you are interested in you are going to enjoy it (Carer 2)

Not all training methods were received well. Staff were unanimous in their dislike of e-learning, mainly because they viewed it as being a 'tick box' exercise and it was not viewed as providing evidence of competence in practice:

...there is going to be more e-learning, so I think it is something like 67% of the training that you get from our company is going to be actually online which is a bad thing I think because how can you prove that somebody is competent after ticking a few boxes, do you know what I mean? You might guess that the answers are right and pass it, but who is saying that you are actually putting that into practice? It just puts their figures saying that yes, yes, these people have all done blah, blah, blah and there's the evidence to prove it, but that might prove that they have done the training but it's not proving that they are competent in that training. Like I say, how many people just, it is like a yes or no, true or false you know, or pick the right answer out of A, B, C, D and who is to say it wasn't just a lucky guess, and did they retain that? (Carer 2)

The dislike of online ways of working extended to the role of mentor. The following carer describes the value of face to face mentoring compared to online mentorship methods:

Well a lot of it is computer based but I do like to take the time to actually sit down with somebody on a one-to-one basis and find out their actual thoughts

and feelings rather than waiting 2 weeks for them to reply to the email through the computer. I mean I am terrible with computers as well but I do recognise how important they are in the advancement of things. Sometimes my daughter teaches me how to do things. But yes, actually sitting down and sometimes you can type things down but you can't get the emotion and true feeling behind how somebody does feel about how they're doing within the workplace environment. They might feel that they are doing absolutely wonderful or absolutely terrible and the face will give away, their expression will give away some of their emotions so that you can dig a bit deeper and hopefully move things forward for them and find out how they need to improve things or if they feel that they can ... if they feel they are being held back and they want to move forward then we can work on moving forward and find new skills for them to develop (Carer 1)

Dreaming

Finance

For some, financial investment in education and training would make the biggest difference to their lives. The short term investment in staff was viewed as having the potential to reap rewards in terms of staff loyalty:

Well the cost of education is what holds people back or what can hold people back. Me personally, my own situation, that's one of the things that's holding me back from further development. So cost of education, you know of companies such as this could put in grants to help their staff improve them further with the possibility, or with the likelihood of them coming back and returning what they've been given so to speak, coming and working for the company afterwards. Personally that'd be something I'd love to do because this is the type of environment that I love. I do believe some people are born into this type of work and I certainly was, I wouldn't want to do anything else (Carer 1)

...how can I study if I don't have the money, so it is a financial issue...but if people will help me to grow, I am willing to sacrifice my work, as a full timer and then instead by full time with my study and part time with my job so I can grow... (Carer 3)

Access to Information

Having greater access to information, to support their caring role was viewed as important to the following respondent. This would support their ability to become a more autonomous practitioner rather than having to ask others for information, something that was viewed as delaying the development of appropriate care plans:

...sometimes I feel if I had access to a computer then I wouldn't have to go prodding people to do things for me. If I could google a certain symptom or condition then that would help me implement my care plans because I could gain the knowledge more easily than going to the office and saying, 'Can you Google a certain condition?' and then having to wait, I could just do those things myself (Carer 1)

Staff

The following respondent, who worked night shifts, suggested that having another senior carer on the team at night would make a difference to their development.

During the night, there were fewer team members which could lead to difficulties:

...we don't have a care leader during the night. It's just a nurse and the rest of the carers...I don't want to say things go wild, because they don't, but...it's not as structured as it could be. If we could have a care leader during the night, someone to take the reins when things go pear shaped, to say, okay, this is this, this is that, because sometimes the nurses are just a bit busy and well, it's too much for them, the whole home... (Carer 4)

For the next respondent, not necessarily having more but having the *right* sort of staff was very important in an ideal world situation:

I sometimes think that, I don't know, can you afford to be picky about who you employ. Some people come into care and it's not about like that's the job they want to do, it is just that's the job that's there, do you know what I mean? You don't really want those people working for us.... you know those ones that just kind of walk straight past and say 'I will be back in a minute' they need to keep

on walking straight out the front door, because that's not what it is about (Carer 2)

Flexibility

The need for flexibility was described by one respondent who was unable to access training or education due to working night shifts although they stated that they would be happy to start their shift earlier to accommodate training:

They do courses, right, but then working nights, as I am, it's mainly impossible to come and do this training. Not the mandatory ones, obviously, those ones you do have to come! (Laughter) But it's just the other ones. If they come up. Let's say I'm working tonight and there is (training) the next day or the whole day, I can't stay awake. If maybe it could be done at different times, let's say, because I know for sure we wouldn't mind coming in two hours earlier to do a little bit of training now, a little bit of training the next day and things like that. We wouldn't mind coming two hours before a shift. That wouldn't be as bad as staying the next day for four hours... It's always difficult. It's always difficult. You can't just please everyone... (Carer 4)

However, apart from night working the respondent accepted that home commitments might mean less time to consider further study:

If maybe the point I am at my life at the moment, with small kids, not yet in school, ooh, maybe I don't have the time yet. And obviously they're kids. Working nights. When am I going to study? (Carer 4)

The next respondent identified the need for good will on the part of the staff if they are going to access further education, if companies are not going to invest in development:

Well you've either got to have a lot of people that are willing to give up their time for free or time and money invested because obviously if people are coming in one set days and it is not their day in work, they are either giving up their free time, their family time and a lot of people want compensation for that type of thing, don't they? It needs investment from money and people (Carer 1)

The same respondent continued by describing the need for person centred education, which took into account the individual needs of staff. 'On the job' training was not always suitable as simultaneously, there are the needs of the resident to take into account, along with the needs of the learner:

There should be time allocated to ensure that people are receiving the right training so you can sit down with people and find out their needs and wants. So, on certain days a week people attend a lesson and you can impart knowledge through those kind of environments. On the job training is fantastic but you can only direct it at smaller numbers...the person that you are teaching them about is not an object, so you have got to remain person centred as well as teaching, which can be difficult...having the structure and time to take with individuals and make sure they have learned and you know, teach them those new skills... (Carer 1)

For this respondent, face to face education had multiple advantages over e-learning when considering person centred education:

...we have what is called the xxx system for education at the moment and I have found it a little bit wanting. There are certain things we do on there that we used to do on a one to one teaching basis. There's no room for questions for people. They can write the questions down at the end and we can get back to them with the answers but I think it's more beneficial if while they are learning it, they are answering the questions (Carer 1)

Summary: Carers

The carers in the sample were passionate and committed to their roles in the care home setting. There were open to multiple methods of education although dreamed of more flexibility of provision and choice of development. Some respondents described a desire for development which would lead to a different role although others suggested that home commitments would prohibit further learning at that time.

- Carers had passion and an enthusiastic attitude to care home work, wanting to make a positive difference to the lives of the residents

- There were a lot of education and development opportunities available for staff although the predominant method was via e-learning which was not a popular choice for some. Person centred and flexible education was described as important for staff development and engagement
- Further financial investment and an increase in resources were viewed as the main factors which would support education and development for staff
- Having appropriate and increased numbers of staff would be helpful to the development of other carers

The Workshops

Introduction

The overarching aim of the workshops was to explore the 'Dreaming' phase of AI and to explore new ways of thinking about the future. Themes from the interviews were used to inform the workshops although it was important that these did not restrict thinking and the 'what might be' focus was enabled. Ultimately the research team wanted to develop a series of 'Provocative Propositions' described by Hammond (1998: 39) as having 'meaning well beyond words, reminding participants of what is best about the organisation and how everyone can participate in creating more of the best'. It is important that these are generated by the participants based on their own thoughts and aspirations for the future. Indeed, during the workshops the research team encouraged the participants to write the propositions themselves, using their own words, to ensure they were meaningful to the group and explicitly generated by them.

Each of the activities are listed below with a description of the main findings. The sample comprised 24 carers (some senior and some having been in post for only 2 weeks), one qualified member of staff, one chef and 2 student nurses. Some of the participants were comfortable to join in with the workshop method although others were happier listening to their colleagues and offering little in the way of their own thoughts. The researchers did not want to pressure staff into taking part if they were uncomfortable to do so.

Activity One

Discuss a time when you felt you had a really good learning experience. It might have been when someone took an interest in you, spent time explaining something to you or when someone showed you a new skill.

The aim of this activity was to encourage the participants to talk and share something about themselves, using photographs to support their narrative.

Described as 'Evoke' cards, the photographs were designed to evoke memories, and thoughts about learning experiences. The cards were spread out on the floor and participants were given time to choose one to bring their learning story to life. Some individuals provided individual responses to this question whereas others created a group response, on flip chart paper, remembering a positive group education session or event.

Responses

What followed was a discussion of many positive stories about times and events when staff felt they had developed in some way. This might have been on a formal or informal setting and ranged from learning new knowledge or feeling they were being promoted in their role:

Stepping up as a nursing assistant; increased job knowledge including phlebotomy, wound care and medications - at the time it was exciting feeling empowered with greater responsibility for residents and staff'

The 'Caring Leaders Programme' - I realised I knew more than I thought and became confident through the session, asking and answering more questions. I came out empowered to put it into practice'

NVQ training: 'Starting it – I was excited and it felt like a stepping stone to further my career. I was proud to be asked to complete it. I was on a high when I passed and was excited to do more. It was an achievement and I learned new skills to help with my job and the residents care'

I have learnt how to get residents up in a morning. I felt great as I hadn't done this before so I felt like I was trusted more to get a chance to do this*

**Written by a carer who had been working at the home for only one week at the time of the meeting.*

The major bones in the body x 20. I scored a massive 33 out of 40 which is the highest score the trainers have seen this month out of our group of 10. I felt like I was not so stupid after all and really pleased with myself.

The focus in one of the workshops, turned to the importance of education to delivery of effective care:

Education helps me to deliver more person centred care

Education is like a light shining on me

Education helps me to stop, slow down and think

Education helps me to reach out to people who need my support

The most important thing is how to deliver high quality care to the resident, education and knowledge hold the key to this

The following excerpts were based on a group learning session which was valuable because a Motor Neurone Disease specialist nurse had visited the home and given a two hour talk about the disease. The carers appreciated the way that they could learn and then put the learning into practice immediately with someone in the home with the disease. They also acknowledged the knowledge of the family and had learned a lot from them about the care of the resident. The group listed their thoughts on flip chart paper as follows:

We felt good about ourselves knowing we could do everything for this lady, based on our new knowledge

We learned about this disease

We were able to meet her needs more effectively

We learned about specialist equipment

We felt privileged and proud to have known her because we met her needs

We FELT happy, pleased that we were trained and capable to look after her, we felt more confident and comfortable in front of the family and felt a sense of relief in front of them

Activity Two

Now imagine an ideal world and you have been granted three wishes. In terms of your own development what would these be?

Cooperrider & Whitney (1999) describe the dreaming stage of AI as one where people consider a better future, in line with the ‘what could be’ way of thinking. The research team encouraged the participants to be imaginative and creative to support the ‘what could be’ way of thinking. As the participants generated ideas, it was clear that these were grounded in their own existing work, for example, having access to further information would enable staff to perform more effectively in their role. AI has a non-problem focus and assumes that there is good in all organisations, asking the question, ‘How can we do more of this?’ However, perhaps it was inevitable that the workshops would generate some negative thinking, and this was not ignored. For example, when discussing development for staff, it was noted that some carers were working many hours of overtime to cover for staff shortage. This issue was bound to creep into the discussion and could not be ignored. As suggested by Carter (2006) AI depends in part on the interpersonal skills of the researchers and the ability to maintain a positive communicative style, without trivialising participants concerns, and this was essential.

Responses

The responses are summarised below:

More time for development	Structured Development	Access to information
Sharing experiences	Career Progression	Self-belief and Confidence

Time

The issue of having more time was raised by all of the groups and was by far the most popular wish. Having more time for education and development was viewed as important, especially since in some homes, training was completed in personal time. We visited one home during a period of severe staff sickness and shortage, meaning that the staff we met were all completing extra shifts on a regular basis. One carer had worked 200 hours in the preceding month. This meant that considering education and development was not uppermost in their minds. The staff were tired and being able to get through the day was their priority, without any additional demands.

Structured Development

Staff recognised that there were often multiple developmental opportunities available to them. However some dreamt of more structured development, which was focussed on a particular goal or interest, for example, that of becoming a Home Manager. Having a clearer focus for the future was viewed as motivational for staff. Acknowledgement of their existing skills and knowledge, with a view to developing these in a particular way, was also seen as important.

Access to Information

Many of the staff felt they needed more knowledge and access to information so that they could perform in their roles to the best of their ability. Having more knowledge was viewed as being important for the development of confidence and staff wanted to look proficient, particularly in front of residents and their families. Having quick access to technology was viewed as essential, for example, to look up medical conditions so they would be better placed to look after a resident.

Sharing Experiences

Staff valued the opportunity to learn from other staff in the homes, for example, to learn from qualified staff and engage in shared reflection. Learning from the experiences of others was viewed as beneficial and staff in one home aimed to set time aside at the end of shifts to engage in reflection on events which had occurred during the day. Learning from others experiences was viewed as a valuable source of development and staff felt that some learning could be acquired in this way.

Career Progression

Having a clear route to progression was viewed as an important motivational factor and one which was valued by staff. Staff wanted to know what opportunities were available for them to progress. Some of the wishes did not relate to current work in the care home but were about moving on to other roles or study. One member of staff described how she needed her maths GCSE to apply for undergraduate nurse education although the class was in the evening and due to her work at the care home, this meant she could not attend. Therefore she perceived she was stuck in the care home, with no way of achieving her goal and so for now, this remained a dream.

Self-Belief and Confidence

Many staff dreamed about having more self-belief and confidence which they perceived would support them to undertake their roles. They suggested that one way they could achieve this was by being given more opportunity to practice new skills and gain feedback from others. Further, having more appreciation from senior staff was viewed as something which could reinforce self-belief and confidence in the participants. Feeling validated by senior staff was important and this could manifest

as something like being thanked by the manager at the end of the shift. Staff wanted managers to be approachable so that they could air their views and gain personal support, stating that their own health and well-being was important was just as important as that of the residents.

Activity Three

In pairs write a poem/song/rap about a 'new world' of staff development – how would it look and feel?

In keeping with a 'what could be' style of thinking, the participants were asked to unleash their creative thinking and write a poem/song/rap about a bright future of staff development. This was the final small group activity and by this stage in the workshop, the participants seemed to be accustomed to aspirational thinking.

Generally the groups responded well to the request and all of but one of the groups wrote a song, which they then set to a familiar piece of music, for example, 'Sandra Dee' from the film 'Grease'. Themes arising from the songs were related to having more time and knowledge, the desire to feel appreciated and the need for more money which was viewed as a way to fund further education.

Results

The following was a very uplifting song, performed in a happy way with much laughter throughout. The group seemed very cohesive and supportive of one another:

We are fabulous! (to be sung to the tune of 'Sandra Dee' from the film 'Grease')

'Look at us, we're fabulous!

Got more time for all of us

We've got more knowledge

Cause we've been to college

We're all so happy eeeeeee!

We have learned from otheeeeers

Now we are all like brothers

And we are all so confident...

Like the Queen!'

The dominant theme in the next song was the need for appreciation from other staff and the residents. The home was very short staffed during the time of our visit and some of the staff described feelings of extreme tiredness which seemed to prohibit the development of 'what could be' ways of thinking. Nonetheless, they were still able to describe an ideal learning environment, one in which they felt appreciated and had a desire to keep learning and developing as carers:

Song of an ideal developmental area

Look at me, what do you see, lack of confidence, please appreciate me

Look at me, what do you see, just a carer, no, a person who is clever as can be

Look at me, what do you see, do you see how hurt we can be, speak nicely to me

(this refers to the ways in which residents speak to the carers)

Look at me, what do you see, I have learned lots but what more can I be taught?

(This line refers to the value placed on teaching sessions which were facilitated by the home. Staff enjoyed these and wanted more of them)

Look at me, what do you see, someone who tries but makes mistakes and that is okay as I learned from it

Look at me, what do you see, along day is over and I need a cup of tea

(This followed a discussion about the difficulty of working 12 hour shifts which left staff feeling tired)

The dominant theme during the writing of the next song was one of the need for more money; this would lead to opportunities for learning. It started to the tune 'Money, Money, Money' by Abba although as the team continued to think through the issues, the tune fell away and they began to talk through the words, rather than sing:

Money

Money money, money, so it's like honey

So we can reach our goal

We need time time, time, time in a good, good world

To be confident and gain knowledge

With me and my computer, just me and you

With a bit of e-learning and a quick course too

And a dash of NVQ

With some appreciation and a pat on the back

And a nice thank you when you say goodbye

It goes a long way

The following poem was written with the environment in mind, one which nurtured and supported staff in their learning and ongoing education:

Clean Fresh Air

Nice clean fresh air

Flowers that smell so sweet

Words that we all understand

And written all so neat

Staff who are friendly and nice

Who want to learn all of the time

Staff who smile and laugh

And will make sure you are fine

It's time to go home now

We can all have our say

Everyone is fit and well

See you again another day

Provocative Propositions

Carter (2006) suggests a 'hands off' approach whilst facilitating this style of session, in order to encourage and not stifle creativity. We did not want to drive the workshops in a particular direction and it was important that views and feelings of the staff were enabled to emerge. This was important particularly the development of the Provocative Propositions which were left to the staff to write. These have been summarised below, based on the statements written by each group during the Workshops. The research team only intervened when clarification of points was required:

Provocative Propositions

1. All staff are paid to undertake all training even e-learning (in some homes this was described as unpaid and undertaken in the staff's own time. It was not clear how many staff received time in lieu for this training)
2. All skills are acknowledged and there is recognition that all staff members are individuals and have different learning needs
3. There is appreciation and recognition of the fact that staff work hard – this is praised and valued by senior staff
4. Pay is the same for all carers who do the same job
5. All staff are part of a learning environment that is flexible to individual need (both theoretical knowledge and practical skills)
6. Staff have enough practical resources and space for everyone to learn
7. Staff are in an environment that is supportive with good role models from whom to learn

Home Improvement Meeting

On the day the research team visited one of the homes, some members of staff had organised a Home Improvement Meeting, to which the researchers were invited. The overarching aim of the meeting was to explore ways in which care planning and delivery could be developed at the home. The meeting involved residents, families and staff with a focus the 6 C's of Nursing. This was the second meeting that had been organised at the home, the first had the focus of 'What makes the perfect care home?' A qualified night nurse and carer had offered to lead this meeting, with the support of the care home manager. Therefore it was developmental for these staff

members in terms of planning and facilitation of a meeting. All residents living in the home had received a formal written invitation (the home has capacity for 80 residents, serving residential, nursing, dementia and respite needs). The meeting was attended by approximately 15 residents, 8 family members, 4 home staff and the care home manager.

The underpinning focus was very positive and aimed to ascertain what works well in the home already, whilst acknowledging that developments could be made. The meeting was open to comment about how care could be improved, with a focus on the 6 C's. Many attendees were unfamiliar with this concept therefore there was an explanation of the 6 C's at the start of the meeting, delivered by the night staff nurse. The attendees were then split into groups to discuss elements of the 6C's initiative and how this translated to care at the home.

All attendees were invited to contribute to the meeting in small groups, which raised comments about some excellent practice already ongoing in the home.

Residents described staff as working well as a team, which meant that they got help quickly when required, (for example, they had been able to bring the GP in quickly to see a resident). Important issues raised by the residents included getting their medication on time and individuals commented positively on the ability of the home staff to meet their needs in this aspect of care provision. Residents enjoyed the activities on offer at the home and wanted more choice on a daily basis. There was a request for the development of an area to watch sport, with the inclusion of Sky Sports for those with a particular interest in this.

Carers expressed a desire to spend more 'quiet' time with the residents on a one to one basis whilst acknowledging the often fast paced environment of the home. They

valued time to listen to the residents in order to meet their needs and know them as individuals, in line with a person centred care ethos. This was particularly important for respite residents who stay in the home for shorter periods of time. Carers were keen to expand their knowledge base, for example, of rare medical conditions and valued the input of specialist experts who visited the home to share their expertise.

The staff described a commitment to positive change and confirmed that they would develop an action plan with focused objectives and dates, which would be added to the Home Newsletter. There was a general discussion of the need for commitment to continue positive change and development and it was recognised that involvement from all staff was required in order to achieve this.

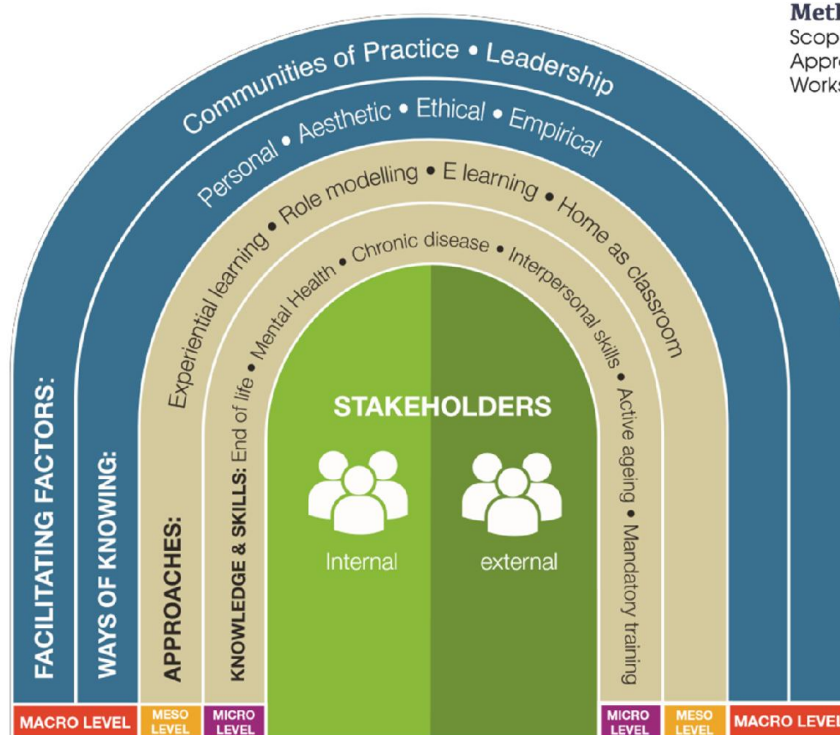
Discussion

Analysis of the interview and workshop data from the 5 homes involved in the research, combined with the results of the scoping study revealed multiple areas of importance when considering the provision of, and conditions for, effective education and development for nursing staff working in care homes. These can be grouped into 5 main domains and are presented as a framework below;

Framework of Education and Development for Care Homes

Approach
Appreciative
Inquiry

Methods
Scoping study
Appreciative interviews X15
Workshops X4



The 5 domains are of equal importance can be broken down into further detail.

Facilitating Factors

The Facilitating Factors are the conditions under which effective education and development thrives. These include Leadership and Communities of Practice.

Ways of Knowing

Based on the work of Carper (1978) these are the fundamental ways of knowing in nursing practice: Empirical, Aesthetic, Personal and Ethical.

Learning Approaches

These are the multiple methods used to support education and development in care home nursing and include; experiential learning, Role Modelling, E-Learning and 'Home as Classroom'.

Knowledge & Skills

This describes the knowledge and skills required to support care planning and delivery in the care home. This list is not exhaustive although based on the scoping study and research data these were the most common aspects, which support effective care in the home: End of Life, Mental Health Care, Chronic Disease Management, Mandatory Training (including, for example, fire safety, infection control and moving and handling), Interpersonal Skills and Support of Independence and Active Older Age.

Stakeholders

It is important to consider the requirements and views of the various stakeholders who are involved in the care home setting. These are both internal and external to the care home.

Facilitating Factors

Leadership

'They know that there are issues, you know, that when issues come up, they can come to my door'

The subject of effective leadership was raised many times throughout the data, when considering education and development of staff. Effective leadership was important at different levels and in multiple forms. For example, some care home managers described the need for support and guidance from other senior members of the care home company; carers valued leadership from qualified staff and care home managers. The most favoured style of leadership seemed to be transformational in style, based on growth and support, and staff valued staff this approach (these findings have been reflected elsewhere see for example JRF, 2012). Bass (2005) describes a main component of transformational leadership as 'inspirational motivation'. Leaders communicate high expectations and motivate staff to share the vision of the organisation (Carney, 2011). Along with the needs of the organisation it is important the developmental needs of the staff in the care home setting are taken into account. With this style of leadership, there is a focus on what staff need and value and in this way, transformational leadership engages 'hearts as well as minds' (Clayton, 2007: 59). Mitchell and Tucker (1992) describe transformational style leadership as being people orientated, rather than task orientated. Respondents in the study liked to feel valued and appreciated for the work they had completed and a 'thank you' at the end of the day was often enough for them to confirm they had done a good job. The data suggests that staff valued care home managers who took an interest in them, not only professionally but also personally. Having an office with an 'open door' was something that managers viewed as important to encourage staff to discuss and question practice. One manager in particular, was happy to be challenged by staff, supporting critical thinking and subsequent development and

learning. Encouraging the proposal of new ideas empowers staff to develop ways to solve problems in new and innovative ways. Promoting an empowered workforce is beneficial, not only to staff but ultimately to effective care delivery.

All of the care home managers wanted to support staff development for example, through CPD courses although in some areas there were financial implications which might prohibit this. Some managers felt frustrated at the lack of strategic thinking by the care home companies, for example, money wasted on recruiting inappropriate staff rather than the funding of longer-term career opportunities for existing staff, or used as a means to attract motivated staff into the care home setting. Senior staff valued the networking opportunities open to them for example, managers meetings with others in the geographical area. Managers described care home work as being viewed as the Cinderella service and often felt disempowered by others who talked down to them, for example other members of the MDT. However, as passionate leaders they advocated for the speciality of care home nursing and this was viewed as something which might raise the profile of the work.

Many of the staff interviewed described care home work as a speciality and one where they could build up meaningful relationships with the residents, which led to effective care provision. The managers highlighted some of the responsibilities attached to care home work, such as managing budgets and large staff teams, and how these differed to working in the acute sectors,. The qualified staff and carers discussed the differences in care delivery, to that in the acute sector, for example, the ability to develop meaningful relationships with the residents and families in care homes and be able to provide person centred care on an ongoing basis. However, some staff described dissatisfaction at the way other members of the multidisciplinary team, for example, paramedics, who might not acknowledge their

skills or value their opinions, treated them. Some respondents were frustrated at being viewed as a 'last choice' for nursing careers when they perceived their roles as challenging, autonomous and requiring innovative thinking and advocacy for other staff and residents.

Staff described feelings of disrespect from other members of the MDT and perceived that they did not always take them seriously. There are high-level skills required, for example, by managers of care homes, not only clinical but financial knowledge. Further, for those homes relying on charitable funding, income-generating ideas were constantly required in terms of acquiring funding for resources, decoration and upkeep. If care home nursing is viewed as more of a speciality, there could be opportunities in terms of investment, recruitment, sustainability and quality. There was a sense at times that care home nurses felt that they were 'done to' rather than being 'worked with'. This led to feelings of disempowerment and had negative effects on education and development.

Developing Communities

'It is very good for bouncing off ideas to find other people have had shared experiences'

The findings of the scoping study suggested a need for networking and sharing of resources and education across care homes. As Spilsbury et al (2011) state, care home nursing can be isolating with qualified nurses working with higher proportions of carers rather than peers with the same qualifications. Through the research we found that many qualified staff were working alone, supported by a number of carers, for example, six carers on a care home 'floor' working with one registered nurse. Not only is networking effective for sharing education and good practice, it affords opportunities for peer reflection and clinical supervision. One way to share good

practice and learn from others in a similar situation is through communities of practice, described by Wenger et al (2002: 4) as ‘...groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis’. Typically communities of practice discuss issues, share understanding, create new ideas and are reassured that they are with others who understand their perspective. It is not necessary that such communities work together on a daily basis although meeting is valuable and over time, they develop a sense of identity. Positive changes related to such communities have been documented most recently through the Care Home Vanguard Framework (NHS England, 2016). This work seeks to improve the quality of life for people living in care homes and communities of practice include multi-disciplinary meetings aimed at sharing knowledge and expertise to inform care planning in complex cases. Respondents in our study described the benefits of such communities of practice and this was most notable among the managers and qualified staff. One manager described meetings, which were helpful to encourage ‘out of the box’ thinking and sharing of good practice, which could lead to improvements in work practices.

Ways in which some of the care homes developed ‘communities’ extended beyond care home staff, as some respondents described how they reached out into the geographical community to develop good practice. These initiatives might not be described as communities of practice in the formal sense, although they were viewed as important when, for example, trying to change societal perceptions of older people. Some homes in the study invited local school children in to visit the homes. The focus of the visits differed depending on the aim, for example, one home manager invited young children to come in and bake cakes with the residents. This

was beneficial on both sides of the relationship as it provided opportunities for residents to interact and share their knowledge and experience to others and provided children with positive experiences of older people. Other ideas included inviting groups of school children into the home, to dispel negative myths about care homes (often emanating from the media and television programmes such as Panorama). Ultimately, reaching out to the community in this way was aimed at changing perceptions of care homes and older people as it was acknowledged that the media report the horror stories and not the excellent practice occurring in many areas. Some respondents describe the need for long term thinking in order to future proof care homes on a long term basis, based on the belief that if young people have positive views of care homes now, they might be more likely to choose a career in a care home setting later on in life. Some homes had local community college age children undertaking work experience in the homes and in one case this had led to them being employed as a carer upon leaving school. The need for creative thinking around long term career pathways was described, for example, college age children doing work experience could ultimately lead to them being sponsored by the home through undergraduate nurse education and then returning to work as a qualified nurse in the home

Ways of Knowing

'You are going to get used to them on a personal basis and they can get used to you on a personal basis and I think you can get more out of a resident...'

The respondents in this study described multiple ways of knowing to guide their work with residents in the care home setting. Through the data we were reminded of Carper's (1978) Fundamental Patterns of Knowing which are described as Empirical,

Aesthetic, Personal and Ethical. These are the different types of knowledge nurses use to support their work (Based on Carper, 1978).

Way of Knowing	Description
Empirical	Gained through scientific enquiry, knowledge that can be empirically verified
Aesthetic	Gained through the 'art' of nursing, for example, empathic knowledge
Personal	Knowledge of the self which can be used to strengthen the therapeutic relationship
Ethical	Knowledge based on moral duties, obligations and ethical frameworks

Empirical Knowing

Respondents in the study valued factual education especially that which supported their ability to deliver effective care to residents. Mandatory education such as fire safety and infection control can be used to guide predictable situations in the home and can be used effectively to guide practice. Results of the scoping review revealed many educational interventions, covering a range of subjects, whereby specialist nurses delivered education to care home staff, often for example, as one off ventures, and educational sessions about dementia or chronic diseases such as diabetes. The respondents in our study gave positive examples of factual teaching sessions of this style, which had supported them in caring for residents, for example, education about Motor Neurone Disease. This was relevant to the staff as there had been a resident with the disease admitted to their home and they had enjoyed

gaining different knowledge, which would support care planning and delivery. However staff wanted more access to factual information in the home at the time of need, for example, if they had a question about an aspect of care, they wanted immediate answers. Relying on external speakers, although beneficial, does not necessarily empower staff to seek out required information, which is relevant at the time. Further, having a high turnover of staff means that training needs to be repeated which might be costly and difficult to arrange.

Aesthetic Knowing

Respondents in the study recognised that not all of the demands of care home nursing could be met by empirical knowledge alone. Often they found themselves in unpredictable situations which required a less tangible and flexible way of being. One respondent gave an example of the type of situation requiring aesthetic knowledge, whilst caring for a person with dementia. Having empirical knowledge of the disease process and the effects on the person is essential although being able to adapt in different ways, depending on the residents behaviour, enables more individualized care. Much aesthetic knowledge development seemed to occur through shared reflection on experiences, with the more senior staff supporting others to understand the nuances of care home work. Some of the homes adopted a model whereby qualified staff employed by the home delivered training to carers on a formal basis, for example, dementia care. This was beneficial as it meant that in addition to the formal empirically based teaching session, carers could continue to question and reflect with the facilitator on an ongoing basis during the day-to-day life in the home.

Personal Knowing

Personal knowing enables the nurse to understand their response to certain situations, which in turn can influence the relationship with the resident. For example, nursing a dying resident might evoke painful memories for some staff and this might affect care delivery at that time. Some respondents described the meaningful connections they could develop with residents and their families and this was an important distinction made between care home work and care in the acute sector which was viewed as more medical in its provision and less patient centred. Connecting in this way might involve giving something of the self, for example, sharing information and thoughts with the residents. Central to care home nursing was the way in which staff could deliver person centred care based on long-term relationships with residents and this was important as it meant that staff could start to know residents in different ways and understand them as individuals. A project in one of the homes had centred on ways in which staff could get to know residents more meaningfully. This meant that staff could be matched to certain residents who shared similar interests. One example was matching a resident and a carer both with an interest in football.

Ethical Knowing

At its core, ethical knowledge, 'requires us to make judgments on what is right and wrong' (Garrett & Cutting, 2015: 100), often based on our cultural and personal beliefs. Nurses are often faced with difficult and uncertain situations and the respondents in our study described such times, for example, when working with residents with dementia who become aggressive. Some carers described feelings of hurt at the ways in which some residents spoke to them and it is at these times that they could either judge the behavior or consider their own reaction to it. Education about why residents behave in certain ways was described as important by some

respondents, so that staff can understand the reasons why the behavior occurs, and deal with it appropriately. The scoping review revealed end of life care as another area where education and training was essential although experience and changes in care home culture were viewed as equally important (see Johnson et al, 2013). Carper (1978) suggests that moral distress occurs when the nurse's view, to promote health and life, is in conflict with the clinical decisions being made by others. Many residents will end their lives in care homes and nurses need to balance their own beliefs with those of families and the decisions of other health care professionals.

Learning Approaches

The data and scoping review highlighted many different learning approaches which were utilised to deliver education and training to staff. Due to the high turnover of staff employed by care homes, there are issues surrounding the need to repeat training as new staff arrive, therefore approaches are required to be flexible and responsive to needs of homes. Along with formal 'methods' some approaches were described as more informal, such as role modelling, which happened opportunistically in the home although no less valuable to staff. Staff wanted to learn in ways, which recognised their different learning styles and were flexible in their approach, for example, for staff working night shifts.

E-Learning

'I must admit when e-learning came in I wasn't really an advocate for it...I've been convinced otherwise'

Attitudes to e-learning were mixed, with some staff viewing the method as helpful but others believing that passing e-learning module assessments was merely about

ticking the correct boxes than gaining meaningful learning. Some staff viewed e-learning as a beneficial method for under confident staff, who might not like to ask questions in a formal classroom setting, in front of their peers. Certainly e-learning methods can be beneficial in terms of their flexibility and low cost (Ruggeri et al, 2013). This is an important consideration in the care home setting as it means that staff can complete the learning at their own pace, away from the workplace. Indeed, some respondents reported the completion of modules away from the busy care home environment. However, respondents in the study valued learning from others and peer support was viewed as valuable across many of the homes. E-learning was not viewed as supporting peer learning and was seen as a more isolated way to learn. Peer learning supports active collaboration among staff and is developmental on both sides of the relationship. For example, a more experienced member of staff might be able to share their knowledge of a particular disease process, whilst also developing their communication, teaching and leadership skills. From the other perspective, a more junior staff member will learn from someone they already know and with whom they feel comfortable. The data revealed some examples of occasions when peer learning occurred and staff were able to share not only empirical but experiential knowledge which supported their development and ability to care for particular residents. E-learning developments might include the use of discussion boards and or joint working, to support peer learning using this method.

Experiential Learning

'I think a lot of dementia care comes from experience...there's only so much you can learn from a text book'

Respondents in the study valued learning from experiences and understood that reflecting on care lead to new understanding and development, for example, when considering nursing people with dementia. Reflective learning took place in different ways, for example, during formal appraisals, sometimes called 'supervisions' and more informally, during day-to-day care delivery. Such was the value of reflective thinking that one home in the study had begun to arrange formal reflective sessions to think about practice at the end of each shift and this was the focus of their project work with the Foundation of Nursing Studies. Reflective practice is a familiar concept in nursing work and involves learning '...by thinking about things that have happened to us and looking at them in a different way, which enables us to take some kind of action' (Jasper 2013: 3). Reflecting on experiences can support nurses to cope with the emotional nature of caring work and helps to develop emotional self- awareness (Rees 2013). Many care homes are now providing care for residents with increasingly complex nursing needs and the majority of residents will die within twelve months of admission to the home (Kinley et al, 2014). Therefore, the consideration of the emotional aspects of end of life care need careful thought if care staff are going to be adequately prepared to deal with such situations. Hockley (2014) described the use of reflective debriefing groups as a means to support learning and thinking about death and dying in a care home setting. Staff valued the opportunity to discuss the deaths of residents they had cared for, and felt able to open up and clarify their beliefs about end of life care.

Role Modelling

'We have senior nurses, or senior leaders, in each unit... they likewise will have those difficult conversations and sit down with people and role model'

Role modelling was an important aspect of learning and development in the home. This was usually modelling by a senior to a junior member of staff. Respondents in the study were able to cite examples of when they had modelled behaviour to others or alternatively, when someone else had positively influenced them through modelling. These were often described as memorable occasions, which had left a lasting impression on staff in terms of their knowledge or confidence development. A role model is described as someone worthy of emulation, a positive example of a professional (Perry 2009). Role models not only support professional development but also clinical competence and confidence in others (Cruess et al 2008).

Confidence development was viewed as important, particularly by the carers in the study. To support confidence development there were times when high expectations had been placed on staff, requiring them to step out of their comfort zone in order to achieve a particular developmental objective, for example, speaking to a GP on the telephone. What was important from senior staff, at these times of high challenge, was simultaneous high levels of support for others, so that their confidence was developed and they were not left feeling isolated and unsure. Sanford (1968) described a 'challenge and support' theory relating to university students, which would seem appropriate to apply in the care home context. According to Sanford, maximum growth occurs when people are both highly challenged and supported in equal measure. Conversely, staff become disengaged when they are unsupported and unchallenged. When this occurs, they do not progress and feel unoptimistic about the future. An example of this might be a carer who wants to progress to become a qualified nurse although is unable to obtain the essential qualifications to apply to university. Without challenge and support to achieve these, there is a

potential for the carer to disengage with current work, feeling stuck in a dead end situation.

Home as a Classroom

I quite often do little session if we have got somebody with diabetes, if they are interested they will ask, so I will spend 10 minutes explaining things...

The respondents provided many examples of opportunistic education delivered in the care home setting and all staff in the study viewed this positively. This style of education occurred at all levels, for example, care home managers teaching carers; senior carers supporting novice learners. Some qualified staff described satisfaction at being asked questions by carers and valued enthusiasm shown by others to learn new things. Learning in this way was viewed by some as being more beneficial than that gained on formal courses as it was 'in the moment' and seemingly more relevant to practice. Some staff viewed the home as a 'live' classroom, where learning was going on all of the time. Other qualified staff viewed opportunistic teaching sessions as a way to support the development of autonomous practice in other staff. Having the knowledge behind some of the routines was viewed as beneficial, for example, when residents were 'turned' to prevent pressure sores. Some qualified staff were trainers for specific disease areas such as dementia and it was their responsibility to deliver education to other staff working in the care home. However, for some staff, this role was going to be taken over by external educators coming into the home to deliver education packages. This meant that the staff working directly in the home might have their role as an educator reduced.

Two Adult Branch student nurses were involved in this research, and took part in one of the workshops. Not all of the homes were engaged in mentoring students although

all of the respondents were positive about the prospect of students being exposed to care home nursing. Indeed, exposing student nurses to a positive care home placement during their undergraduate education, might change their perceptions of care home work in a positive way and encourage them to engage in it as a 'first choice' career destination. Having negative placement experiences as a student might be one factor, which dissuades students from choosing to work in older peoples settings upon qualification (Grealish et al, 2010). The quality of the supervisory relationship is the most important influence on the student experience in care homes suggesting that the links between educational settings and the home need to be strong (Carlson & Idvall, 2014). Brown et al (2008) describe the need for an enriched learning environment, which includes having focused learning objectives for students and nursing home staff who are prepared to welcome and work with students, to promote an effective placement experience. Students value staff who show enthusiasm for and specialist knowledge of care home nursing. Further, it is important that Faculty staff portray care homes as a positive learning environment, rather than one with few prospects. Attention needs to be paid to the messages academic staff pass on to students. The role of the link tutor is important as they work closely with the home and provide the bridge between the academic and practice settings. Kerridge (2008) suggests the need for the link tutor to work with students in the home, providing, for example, emotional support for students who might be exposed to death or dying residents for the first time. Care home staff can also benefit from the link tutor role, for example, when undertaking the educational audit, required before students can take up placements. This process is developmental for them, as they are required to consider how to develop the care home environment into a formal educational space. This might require resources

such as student welcome packs, notice boards and a particular area where students can access information, such as journal articles and internet access. Kerridge (2008) suggests that care home nurses might not always be able to take up CPD opportunities due to cost and resource implications and further, the isolated nature of the role can be problematic. Our data revealed similar issues in that some staff could not be released for CPD, for example, to undertake the nurse prescribing course.

Managers in the care homes were happy to welcome undergraduate nurses into the setting although were keen to promote appropriate placing of students rather than the home being viewed as somewhere to 'fill the placement gaps'. This was frustrating for staff, who wanted to provide students with a meaningful experience. Further, staff felt that the link university was devaluing the care home setting as a learning experience by placing students inappropriately. As Lane & Hurst (2012) suggest, the need for placements alone does not justify placing students in care homes and there needs to be careful thought about when students undertake a care home placement, rather than merely to fill a gap. They propose a purposeful placing of students, dependent on the stage of education. For example, students that are more senior can gain knowledge and experience relating to nursing leadership, policies and working with families, having gained technical skills already, earlier on in their programme. This vision was supported by the data in the study and extended to learning about finance and budget management. Lane & Hurst (2012) report on a model to enhance gerontological knowledge and associated experiences in care homes. The 'Brenda Strafford Foundation' has three overarching aims:

1. To promote excellent nurse education in the specialism of gerontology, at both under and post graduate levels
2. To attract nurse graduates into leadership roles within the care home setting

3. To provide ongoing education to care home nurses

Not only does this benefit students needing clinical placements but is beneficial to staff who require CPD. Furthermore, by promoting excellent relationships and effective CPD, students might want to take up care home work upon qualification, if they can see opportunities for career development. Generally, students have positive attitudes and perceptions of older people and it is important that academic staff collaborate with the care home industry in order to develop relevant and innovative curriculum in order to develop the older person workforce (Neville & Dickie, 2014). The skill mix of staff in care homes is different to that found in hospital settings. Often there is only one qualified member of staff working on a 'floor' supported by a number of carers. Alternative models of supervision need to be explored through collaboration with Faculty and care home staff in order to create an effective learning environment for students (Grealish et al, 2013). Indeed qualified staff in our study described very busy situations and times when they were unable to complete their work during a shift. The additional time required to support a student, might be unmanageable for some staff unless changes were made to staffing and resources. Further, releasing qualified staff to attend mentorship preparation courses might be difficult. Some respondents in our study described barriers such as; the cost of mentor preparation and the cost of replacement staff to cover those attending training.

Knowledge and Skills

If I could Google a certain symptom or condition then that would help me implement my care plans because I could gain the knowledge more easily...

Staff distinguished care home from other types of nursing and viewed it as a speciality. Unique to this provision was the building of relationships with residents and families and a ‘patient’/resident centred care ethos. Residents in care homes are often frail and vulnerable and have increasingly high levels of care need, which requires specialist knowledge and skill e.g. palliative care, mental health care and chronic disease management, in a home style setting. Some staff highlighted the fact that although the home was their workplace, it was where the residents were living and for most, this would be their ‘last address’. This aspect of care home practice was very meaningful for many staff and they wanted to ensure that residents could live as full a life as possible whilst living at the home. One manager went so far as to describe an imaginary motto to be placed over the care home door; *‘This is not the end’*, such was the passion for residents to be able to lead fulfilling and meaningful lives, even if this would be the last place they would live. Based on the scoping study, interview and workshop findings the following knowledge and skills seemed central to care home nursing:

End of Life Care	Mental Health Care	Chronic Disease Management
Mandatory Training	Promoting Independence and active ageing	Interpersonal Skills

End of Life Care

It is estimated that one fifth of the UK population die in a care home (DH, 2008) although education on end of life care has not been a priority in the preparation of health and social care professionals (Johnson et al, 2013). Few respondents in our

study raised the subject of end of life care during the interviews and workshops in comparison to dementia awareness and the management of chronic disease. One qualified member of staff described an interest in palliative care and the perspective from one home manager was that end of life was managed well at that particular home. However, findings from the scoping study revealed some interesting points most notably from Froggatt (2001) who suggested that there are many assumptions made when considering end of life care in these settings. For example, models from specialist settings can be easily adapted to the care home and further, that education is enough to bring about positive change. One care home manager described the need for support for an end of life care nurse who was employed by the care home, with a view to the role being shared across a geographical setting, suggesting that there are particular nuances related to end of life in a care home in contrast to a specialist palliative care setting. There was a desire for more specialist progression routes for nurses in care home nursing as current promotion pathways were restricted to that of becoming a care home manager. However when considering specialism there were resource implications in terms of costs and continuity of care; whilst the employee is away on a course, who will provide the care in the home and further, the cost of education was deemed as too high by the care home company.

A unique aspect of care home nursing is the length of time staff spend building up relationships with residents' family members and friends which would make them ideally placed to provide care at the end of life. Some respondents described the long, difficult and emotional journey taken by families, when admitting their loved one to a home. However, these relationships can be beneficial particularly when having difficult conversations such as those at the end of life. One third of care home residents admitted to hospital die during the admission (Dwyer et al, 2014) which

suggests that they were very close to end of life at that time. Having the confidence to talk to families realistically about end of life, might prevent admissions and enable residents to die peacefully in the care home setting. However, results from the scoping review suggested that care home staff needed further development of skills and confidence in order to have end of life conversations with families (Stone et al, 2013). Johnson et al, (2013) suggested that education alone was not enough to change practice and described the need for changes in culture, systems and care home practices to enable person centred end of life care. However, care does not exist in a vacuum and input from the wider MDT is required to deliver specialist care, which in turn might prevent admission to the acute setting. Links to specialist nurses and Geriatricians can support care homes in their work (British Geriatrics Society, 2013). However, a fortnightly visit from a Consultant Geriatrician had recently been withdrawn from one care home in the study, adding to the belief that care of the older person was not viewed by the local CCG as a priority. A combination of collaboration with a wider team along with increased specialist care home nursing knowledge could potentially have a positive impact on admissions to hospital, and encouraging results have been shown in the Care Home Vanguard work (NHS England, 2016).

Mental Health Care

Dementia is an international health priority as 46.8 million people worldwide have the condition, with this figure set to double every 20 years to reach 74.7 million by 2030 (Alzheimers Disease International, 2015). Many people with dementia will end their lives in care homes and many of the respondents in our study were involved in dementia care. Our study revealed that caring for residents with dementia was an area of practice where knowledge and experiences were passed from senior to

junior members of staff often in an opportunistic way, during day to day work. Data from the workshops revealed the challenges of caring for people with dementia and some carers described feelings of frustration at the way they were spoken to by some residents suffering from the disease. Indeed caring for people with dementia can place a high burden on carers who at times did not fully understand the reasons why some residents behaved the way they did. There were a number of strategies identified in the scoping study which might support staff in dealing with challenging situations, for example, scenario based training and the need to encourage staff to consider personal strategies to develop their practice. Some respondents (care home managers and qualified staff) had a particular interest in dementia care and had undertaken further study in this area. However, the delivery of formal educational sessions was sometimes restricted due to short staffing which lead to gaps in the delivery of the training for carers. In terms of mental health care, the data was dominated by discussion of dementia care. However, depression in older people is important to consider as it has been suggested that older people living in care homes are 40% more likely to be depressed than those living in the community (Age Concern, 2006) and people who have dementia can also be suffering from depression. None of the respondents in our study described caring for a resident with depression specifically although many described their passion to make care home life the best it can be for the residents, perhaps unconsciously acknowledging the potential for depression to occur. One respondent described the risk for people to feel abandoned in a care home and there was an obligation for staff to make the most of what they could for the residents, although staff described no depression specific education or training.

Chronic Disease Management

Most people over the age of 75 have a long-term health condition and the prevalence of chronic disease rises with age with more people living longer with multiple health conditions (Age UK, 2015). Inevitably many of these older people will be resident in a care home and those who would normally be cared for in hospital are now finding themselves admitted to care homes, requiring more complex nursing skills and knowledge than ever before. Respondents in our study, particularly the carers, were enthusiastic about having more knowledge so that they could plan and deliver care effectively. This was particularly important when a new resident was admitted into the home setting and staff wanted to know how to provide the most effective care. Staff valued input from specialist nurses, the most notable example being the workshop relating to motor neurone disease. Data from the scoping review suggested the development of protocols, which could be used to assess the quality of care, for example, for residents with diabetes. Due to the relative high turnover in staff working in care homes, rolling programmes of education might be required and leaving educational materials at the home was one way of supporting a transient population of staff. Staff shortage was a main prohibitive factor to development along with lack of knowledge of training opportunities and minimal employer encouragement for such things.

Mandatory Training

Respondents in our study described a lot of mandatory training, which was available to them through the care home. Subjects such as fire safety, infection control and moving and handling, were delivered often by home based trainers. There was a move for some of the training to be accessible on line, via e-learning approaches

and this had been met with a mixed reception, with some staff questioning the value of multiple choice training. There were concerns about the risk of guessing rather than answering with the correct information. Some staff were required to complete the mandatory training in their own time although generally they were reimbursed for the time spent doing this. Night staff had difficulty in accessing training at times, due to the daytime delivery. One respondent suggested more flexible delivery, for example, training sessions commencing a couple of hours before the start of the night shift, to make the learning more accessible to night time workers. Findings from the scoping study suggested that in general, for all education and training, flexibility of delivery was important. The workshop data revealed that some carers worked 'long days' meaning that there were not in attendance at the home for the whole week. Therefore any developmental opportunities offered needed to coincide with their working days in order for them to take them up. Rout et al (2010) describe lack of course flexibility as a main barrier to learning and development and this is important when considering mandatory training and something that online learning might address.

Interpersonal Skills

Effective communication is central to person and relationship-centred care and contributes to positive relationships, which facilitate choice and control for older people (JRF, 2012). Respondents viewed shared reflection and role modelling as ways to develop interpersonal competence, and care of people with dementia was the most cited example of when effective communication was important. It has been suggested that care home staff do not initiate conversations with residents and many exchanges are transactional and one sided in nature (Williams et al, 2003). The ageing process itself can raise challenges to communication through sensory loss

and chronic diseases. Further, staff shortage can support a more task focused style of working which can restrict communication, as the need to get through the work takes priority over meaningful interpersonal interaction. Some respondents in our study, described times when they had struggled to complete their work and this had played on their minds, as they had not been able to provide the care they had wanted to for the residents. Respondents wanted more staff on particular shifts, so they could spend more time with residents and this would potentially provide opportunities to interact in meaningful ways. Respondents described care home nursing as a speciality that encouraged the development of long term relationships between staff and residents. Interpersonal skills would seem central to this development and to person centred care delivery.

[Promoting Independence and Active Older Age](#)

Some respondents in our study described a desire to promote independence and meaningful activity among the residents in the care homes in the sample. Being admitted to the home did not spell the end of an active life and this was evidenced by a range of activities and events arranged by coordinators employed by the homes and by the nursing staff themselves. Engaging with local communities was a prime example of this, whereby local children were invited in to bake cakes with residents in one home. This was one way to change societal views of the nature of care homes and further, was a way to engage the residents in activities which they enjoyed. Engaging with local communities has been shown to be successful when promoting active older age and independence. For example, The Community Anchors are independent organisations which can be accessed by the whole community and have been developed as part of the 'Enhanced Health in Care Homes Framework' (HEE, 2016). Through the project, which aims to encourage the

local community to be an integral part of the care home, there has been a reduction in hospital bed days and 16% fewer ambulance call outs in the area of Airedale, Yorkshire, in the last 12 months. The World Health Organisation (2002) describe active ageing as ‘...the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age’ with the concepts of autonomy and independence being central to this. Many of the interventions in the care home sample were focused on the goal of promoting health and active ageing as part of the routine work.

Stakeholders

There are multiple stakeholders with an interest in the maintenance and promotion of ways to support effective education and development in the care home setting.

These are both internal to the home, for example, residents, families, staff and care home managers, and external to the home, for example, care home owners, regulators and other agencies such as primary and acute care services. Each has a different but important interest in the promotion of quality which occurs when staff are educated, empowered and supported. Findings from the Scoping Study and the wider literature suggest the benefits to all stakeholders when staff are supported in their development. For example, findings from the Care Home Vanguard initiative (HEE 2016) suggest tangible improvements in care following developments in education provision, which lead to a reduction in unnecessary GP callouts and hospital visits, improvements in the quality of care and a confident and empowered workforce.

Summary

The overarching aim of this report was to explore the conditions in which education and development thrives in the care home setting. In achieving the aim we have developed a multi-faceted framework taking into account not only the conditions but also the types of knowledge and facilitation required for care home nursing. It is hoped that this framework and associated ideas will be helpful to many groups with an interest in care home nursing, education and development.

Recommendations

These have been based on the findings of the Scoping Study, the data from the qualitative interviews and the workshops. This has been used to inform a set of recommendations which relate to different aspects and the various stakeholders with an interest in the education and development of staff in care homes.

Care Home Companies:

Staff at all levels should be given access to flexible CPD taking into account their differing requirements, based on regular appraisal

Links with Higher Education Institutions could be made to develop reciprocal arrangements for staff development and student learning

Develop attractive career routes for potential applicants, e.g. Managerial and Specialist routes

Care Home Managers:

Promote an empowered and confident workforce through effective leadership

Continue to engage with local communities to promote positive images of older people and care homes

Higher Education Institutions

Develop flexible mentor preparation for qualified care home staff to enable the appropriate placing of students in care homes

Promote supportive relationships through dedicated older people Practice Education Facilitators, who bridge the gap between the home and the HEI

Promote positive perspectives of nursing older people through academic contact with student nurses

Care Home Staff

Continue to recognise the opportunities for education and development, informal and formal

Consider the development of communities of education and practice at all levels e.g. managers, carers and qualified staff

Liaise with other homes to share effective practice and ideas

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A Teaching Care Home pilot



The voices of those who participated in the pilot

April 2017



The voices of those who participated in the pilot

Introduction

This report provides a chance for the voices of the care home staff who participated in the Teaching Care Home pilot to be heard. Far too often, care home staff are underappreciated and far too often, research focusses on the larger-scale, macro picture. The purpose of this report is to allow the true voices of the care home sector to come to the forefront. The opinions of registered nurses, care workers and managers on what needs to change, what will help them achieve this change, and what lessons have been learned from being a part of this Teaching Care Home pilot.

Care homes are often the bedrock of local communities. They may be homes for our grandparents or parents, and we know that one day we may need to move in to one. They are also a boost to local economies, providing employment opportunities to many. But the hidden voices inside the care homes are too often ignored.

This report has been informed by several sources collected during the Teaching Care Home pilot. These include appreciative interviews with members of staff at each Teaching Care Home site; managers, registered nurses and care workers. Evidence is also drawn from blogs written by participants of the programme about their personal journeys and telephone interviews conducted with key stakeholders involved in the care home sector in England.

Chapter 1

In this section, we highlight the key themes that emerged from the appreciative interviews that were carried out by Manchester Metropolitan University. Face to face interviews were conducted at each of the pilot sites, with managers, registered nurses and care workers. We have looked at the interviews through two broad themes; what the interviewees thought is going right in the sector, and what they think needs to improve.

Registered nurses

What is going right in the sector

The registered nurses who were interviewed often spoke positively about the person-centeredness of their work. This was contrasted with nursing in the NHS; in a care home setting, some of these nurses felt that they had the opportunity in their job to form meaningful bonds with both residents and their families. One nurse, who went into care home nursing after doing a student placement there said “I really liked those sort of long term relationships and [the residents] recognising me”. One nurse noted there was often a lot of humour and emotion involved in the job, as they often have more time to develop a connection with the residents and families than they would have if working in acute hospital care. The importance of leadership and good management was also highlighted in retaining talented nurses in the sector. One nurse was particularly enthusiastic about their manager, and crediting them for continuing to work there. They stated “I said I would stay until [the manager] retired”. Another said that they “value my seniors sitting down with me and listening to my concerns... I feel I can be open and honest... Improving standards. Looking at individualised care. I feel I’m listened to”. At the heart of the pilot was the emphasis on using the ‘care home as a

classroom', and this was appreciated by the registered nurses involved. One nurse was enthusiastic and grateful for the responsibility placed in them by the care home company, saying "I wouldn't have put myself forward in the first place but now I feel very confident to deliver training... it's education in a way, it's happening all the time, you are supporting other staff whether you look at it like that or not".

What needs to improve in the sector

The nurses also called for more access to continuing professional development (CPD) - in terms of both developing their own skill set and achieving their career goals. One nurse had the goal of becoming a nurse prescriber, another nurse to become a care home manager. However, they had not mentioned it explicitly to management in the care home. A number of nurses expressed support for continuing to strengthen relationships with universities, colleges and care homes, in order to further CPD. One stated there was a lot of benefits to be had in face to face teaching as there is a danger in e-learning that staff "come in and try to skip the beginning and do the questions... I think you learn more face to face in a more informal setting than a classroom setting... ticking boxes doesn't mean you learn anything". Another nurse also stated that "in-house, hands-on training works better in a care home setting; a lot of their carers "are scared of the classroom experience". As we know, workforce challenges often dominate care homes. One nurse linked the need for investment with more education and training, suggesting that working in a care home needed to be seen as a valid, interesting and rewarding career option, and good education and training on the job can attract high-quality people to the sector. They said "we want to attract people in because they want to come in... it wants to be a place people feel like they can grow and they can be supported and companies have to look at staffing levels". Many of the people involved with the pilot spoke passionately about the existing talent already in their care home. One nurse argued for more investment in training staff already in the care home, who they knew they could rely on, rather than spending money on recruitment just to see the new member of staff leave after a few months. Another nurse argued for clearer career pathways, as "at the moment in this company the staff can't grow... there's a lot of talent we could use there and it's just finding the pathway".

Care workers

What is going right in the sector

Throughout the interviews with care workers, it was clear that a passion and drive to improve the lives of the residents they care for underpins everything they do. They were proud to provide this care and support to their residents and the families of residents. One carer spoke passionately about their drive to provide a home to their residents that is person-centered and as similar to their previous home as possible; they said that family members had cried when they came to the home "because they thought... this is it, my mum will never come out of this place again and yet she was out, active in the community, and it is those kind of things that make the job worthwhile".

With regards to learning and training in their places of work, one carer stated they particularly enjoyed training on communication skills: "it has improved the way I communicate to my residents and their family members... my communication has really changed during all this training I have been going through". It was also acknowledged that training in a formal sense has merits, but is more effective when coupled with real life experience in the care home, or experiential learning. A

carer of 13 years described the importance of this whilst discussing dementia care. “I think a lot of dementia care comes from experience... there’s only so much you can learn from a text book”. They highlighted the importance of being flexible and adjustable to each unique situation, and added “we have the dementia awareness training that goes on but a lot of it comes from imparting personal knowledge as well, like the more experienced carers helping the new employees learn”.

When discussing their role in the care home both during the pilot and in a wider context, the carers who were interviewed identified the importance of feeling valued by management and appreciated by other members of staff. Some carers who were interviewed felt that they were often role models to newer members of staff, a role which they appreciated.

What needs to improve in the sector

All carers who were interviewed disliked e-learning as an educational tool. It was seen as just “ticking a few boxes”, and participants could pass the multiple choice test at the end because of a “lucky guess”. Like the nurses interviewed, they were worried that staff do not absorb the required information if it is delivered online. This dislike appeared to be due to the desire to do their job to the best of their ability; one carer said “that might prove that they have done the training but it’s not proving that they are competent in that training”.

The preference for face to face interaction rather than via email with either their mentors or managers was also expressed by many carers. The lack of investment in education and training was seen by some carers as problematic and a restriction on what they want to achieve in their careers, also practical factors such as irregular and anti-social shift patterns acted as a barrier. Whilst there was flexibility for the mandatory courses, the optional ones which could boost their career were not feasible for many care staff with their working hours. In terms of positive changes to be made, one carer suggested an approach to training which is person-centered “there should be time allocated to ensure that people are receiving the right training so you can sit down with people and find out their needs and wants”. Another carer also requested more access to computers during their working day or night. The current situation in their home means that if they need to research a certain condition, they must go to the care home manager’s office. If they had access to a computer “I wouldn’t have to go prodding people to do things for me”.

Managers

What is going right in the sector

In conversations with the managers, it was articulated that the environment and ethos of a care home is key to getting the best out of staff. One manager described the ethos as “we can”; in other words, staff should not just follow a routine and follow the lowest common denominator in terms of providing care. This particular manager was very strong in their belief that the staff shouldn’t “just follow the routine”. Some of the managers interviewed spoke in detail about their approach to managing staff, and how support for all staff in the care home sector is important. One manager pointed out that “If you have a number of deaths, the staff need support as well... it’s about knowing your staff and being able to support them”.

The theme of the importance of supporting staff was echoed by other managers. One discussed the importance of being a visible presence in the care home, regularly interacting with residents and staff. Another highlighted that their office is “opposite the front door”, making the management of the

care home more visible and accessible. As well as supporting staff and being a visible presence in the care home, managers also expressed the importance of acting as a role model to other members of staff. One described how they “try to set a good example amongst the staff group”. As well as the importance of being a role model, three managers also described how they use a ‘buddy system’ to integrate and train new members of staff. One manager said they always use the same two members of staff to act as mentors, who they “trust implicitly with the care and the way they work, they are good examples for anybody new coming in and they are aware of how the induction programme works”.

What needs to improve in the sector

As with the other staff interviewed, these managers heavily referenced more opportunities and funding for training and staff development as a priority for their care home, a lack of financial resources was identified as a main barrier to this. One manager stated this was particularly relevant due to the acute lack of nurses in the sector. The same manager also stated that another barrier, for carers, is the time staff need to spend away from their shift if they are to complete training. The shortages of registered nurses in the sector and the thinly spread carer workforce are challenges that are connected; one manager pointed out that they “explored the nurse practitioner and nurse prescriber, and it is literally impossible because of the amount of time they have to spend doing the training”.

The managers interviewed did have suggestions on how to improve this situation. Some managers stated that a good care home focusses their limited training resources on committed, passionate staff that want to progress in the sector. As one manager said “if they come to work as a carer and want to progress, we could give them the opportunity... for example, go to college and study health and social care”. Another manager added that it is important to recognise “the people who really do want to be here, who really do want to take on board everything that has been said and developing that person”. The preferred method of training was also discussed; one manager felt there was a need for their staff to be able to have more time to reflect on their achievements and challenges in the week. They suggested sitting down at the end of their working week and reflecting “have we done something well today, or even, this upset me today, did it upset anybody else, to talk about issues that they have that maybe they won’t come to me with ... because they are busy on the floor, they don’t get to discuss it”.

All the managers of the homes who were interviewed were interested in hosting student nurses on placements and three of the care homes did so. The managers described their plans to bring in more student nurses, and one manager discussed potential problems in taking on student nurses and was frustrated at the type of student nurse that they were sent; they were often sent mental health nurses, rather than general nurses. One manager was frustrated that students are sent to the home as a last resort because they can’t find a placement elsewhere. This made the manager feel the home is seen as second class and they wondered if the students feel this too. The manager also felt the staff at the university did not appreciate the reality of care home nursing. They asked “how many university placement teams have actually walked into good care homes recently... How many have actually had a look around and actually seen what good care home placements are like?” One manager strongly felt the image and stereotype of care home nursing was wrong, and not thought out by those who were in charge of assigning student nurses. They stated that care home nursing

gave students important experience in skills such as leadership, budget management, complex clinical care, decision making, innovation and responsibility.

The managers were all passionate about the need to promote a positive vision of the realities of care home nursing, this could be achieved by attracting more student placements, by getting university placement teams to see what working in a busy, good care home is like as a nurse. Another manager also suggested that it should not only be student nurses they are wanting to attract, it should be student physiotherapists and student occupational therapists. Another manager stressed the need to engage with the wider community to change perceptions; they invite the local primary school in once a week, “as you know so many children don’t have contact with older people, this is the only contact they’re going to have”. As well as the perceived negative image held by universities about care home nursing, some managers identified other groups that often held negative attitudes. One manager felt that CCGs viewed care homes as a “poor relation and Cinderella service... I am fed up of being ‘done to’ instead of ‘working with’”. Another manager felt this view of care homes are held by wider society as a whole, who view the only “proper job” in nursing as being in a hospital. The managers frequently asserted that care home nursing is a specialism, with certain skills required that often make it more challenging than hospital nursing. As one manager stated: “If you want to learn about staff leadership, I’ve got 150 staff that need leading. If you want to learn about managing a budget and appropriately staffing units according to our budget, I’ve got £3.2 million coming in and out. If you want to learn about decisions you make and how they would directly affect an individual’s care, I’ve got individuals here with very challenging nursing needs”.

Chapter 2

The Teaching Care Home model placed the people who work in care homes at the heart of the pilot. Throughout, the participants of the pilot were encouraged to write reflective blogs about their experiences of working in a care home and their thoughts on the Teaching Care Home pilot. Included below are a selection of the blogs written, illustrating the day to day experiences of working within a care home.

Case Study 1: “As a nurse leader, your role is to empower your team”

“As a registered nurse working in a care home I know that even when working on my own, I still need a good team to support me. They are the core of my daily ability to meet the expected standards.

Care home nursing is a challenging area of healthcare. While many people see us as simply custodians of routine and tasks, we are so much more than that. The role demands thorough understanding, knowledge and clinical skills in different areas of care. It also requires commitment, enthusiasm and the ability to work autonomously.

Care home nursing is a challenging area of healthcare.

Being involved in the Teaching Care Home pilot has given me the opportunity to listen and learn, observe and reflect. I want to be better at what I do, a better leader, better role model and overall a better care home nurse, so the opportunity to step away from the home and learn with colleagues

from across the country in our development programme has being beneficial. It's helped me to realise that my leadership impacts on the care team every shift we work together.

I see my role as important in ensuring the unregistered nurses I work with are motivated, keen to learn, able to challenge themselves and to challenge me. After all, the unregistered nursing workforce are the unsung heroes of the social care sector. Without them we could not do our job, our residents would not get what they need and the whole industry would be in chaos. They act as the eyes and ears for the registered nurses.

The unregistered nursing workforce are the unsung heroes of the social care sector.

Not one member of the team has it all. But as a team we can be strong, flexible, adaptable, able to play to our strengths and to support each other in the things we are less able to do. The great thing about a team is the diversity within it which means we can respond to the differing needs of our residents and, if well-led, we can use all our strengths to be the best.

I see my role as that leader and role model and aim to help each team member in their unique contribution to the team. To do this, I need to set the tone, be clear on the team's vision and ensure that I really know my team in order to get the best from them. We all learn and respond in different ways and I have been using reflective practice to help us to learn from the work we do each day. We all consider and evaluate if the actions we have taken that day have brought us to the right conclusion for the best interest of the resident. The team values appreciation from their leaders and I aim to always acknowledge good work.

We all learn and respond in different ways.

I have learnt that it takes time to change, but step-by-step I can see how we can move and improve and the changes we are seeing already are positive and enabling. I am excited about leading this change.

Empowering the people you work with simply by giving them permission to try things out makes a long, hard shift much more fun. I encourage the team to ask the "why not?" question rather than first seeing the barrier to change, and to avoid the response "because we have always done it like this".

I encourage the team to ask the "why not?" question.

Empowering the team to take reasonable and rational risk is in contrast to oppressing their creativity, their solution-finding skills, and their freedom to express an opinion.

Our home also doesn't support a 'blame culture' and we embrace practices like reflection to learn from mistakes if any happen. We also utilise 'appreciative enquiry' as a tool to reinforce the actions that went well for our beloved residents and we promote sharing positive success stories to enhance the spirit of the team.

Being a leader is fun, particularly when you support and nurture by providing supervision that seeks the best in everyone. Support and supervision are core to the care home nurse leadership role and it's a privilege to see your team flourish when it's done well."

Minu Mathew, Clinical Lead Nurse at Rose Court Care Centre, Radcliffe

Case study 2: “There’s no need for care homes to feel isolated”

“I chose to work as a care home manager following a busy NHS career latterly in district nursing. Frustrated by the lack of time to do all I had to do, I choose to make a difference in the care home world. I have been in this sector since 1999 and appreciate the challenges and opportunities in equal measure.

The care home world is vast and yet many homes and managers feel isolated. Few have local networks and partnerships with their neighbours, and anxieties about sensitive commercial boundaries often mean people are reluctant to share. Yet, we are one profession and share one objective: to make the lives of those we care for the best they can be.

The need to share is critical and isolation for smaller providers must be daunting. With changes in regulation, registration of nurses and policy, it has never been more crucial to make those links and come together with a strong sector voice.

Some of the myths and paranoia around sharing practice can be quickly dismissed.

Linking across communities can help with learning, particularly around the changes we have to make, and some of the myths and paranoia around sharing practice can be quickly dismissed.

My home was selected to be one of the Teaching Care Home pilots and we have spent the last nine months as part of a development set with four other homes from across the country. We have challenged each other, supported each other, learned from each other and, I think I can speak for us all, in saying we have all felt included. Not one of us has held back in our opinions, sharing of values, approaches and developments. Why would we? We all want what’s best for those in our care.

We all want what’s best for those in our care.

If we can do this across five counties, why can’t we achieve this across our five neighbouring homes?

Being a good neighbour, sharing our challenges and ideas, using each other for revalidation, creating a community of professional sharing: it’s not difficult. Isn’t that what integration is supposed to be about? Not only is integration across health and social care, but also across our providers locally. Surely, this would be better for all.

We need to stop looking through the window into the world and instead invite the world into our home. I think if we did that then we would have a greater profile locally allowing us to create better relationships with our NHS colleagues, share training and learning opportunities, and to challenge each other’s thinking and ideas.

The Teaching Care Home pilot has opened my eyes and mind to new possibilities and ideas.

If we don’t invite people in we are perpetuating the myths of the care home sector as being from a different world, who lack independent thinking and wait to be led rather than seek to lead. Not just managers having a coffee club, but at all levels, shadowing and reflecting together on what we do. A good idea can be adapted to fit your home and circumstance.

Sitting in Greater Manchester the Devo Man ambition of integration of health and social care could be the test bed for building local partnerships amongst homes. The Teaching Care Home pilot has

opened my eyes and mind to new possibilities and ideas about how we invite people in and disseminate our learning. I needed to put my money where my mouth is and we are hosting a roundtable discussion locally to look at the need for more support to care home development and ideas about Teaching Care Homes as a start of that engagement.

I challenge you to think and reflect about how you and your home could engage locally. It's amazing what happens through the looking glass and how much you can learn from what you see."

Karen Davies, Manager Rose Court Care Home Bury

Case study 3: "The hidden talent of the care workforce"

"Music has always been part of my life growing up. My family have always sung and it's been part of how we shared time. Music can make us think of places we've been, people we've been with and can bring back both happy and sad memories.

I've been working as a carer for many years and I can see the impact that music has on our residents.

Our entertainment repertoire has become legendary amongst our community.

I work in a home with a fantastic team, always up for fun, and at the end of a busy week we come together and plan how we will make every day count for the people we care for.

Like many people working across social care we go the extra mile. Our entertainment repertoire has become legendary amongst our community, and it brings us together as equals, carers, family members and residents all having fun together.

It's good to be together outside the four walls of the home and there is always a tale to tell for many weeks after it.

We also hold events outside our home in our local community social club. This is a big occasion for residents and visitors alike to dress up and go out. It's a mammoth operation to take our residents to the 'Stars in their Eyes' competition, which is becoming a regular event, but it's good to be together outside the four walls of the home and there is always a tale to tell for many weeks after it.

For those who are unable to join us we hold a repeat performance in the home.

Creating a community and sharing fun is often the hidden talent of the care workforce.

It demonstrates that the skills to care go way beyond physical ones, including skills to help people reach their potential socially as well as physically and psychologically. It helps us build relationships and create a sense of community.

Creating a community and sharing fun is often the hidden talent of the care workforce. This is after all someone's home, a place where they should feel happy, anchored and safe. Being part of an extended 'family' is all about sharing and having a place where you can be yourself.

For some of the people I care for, connecting through music is sometimes the only way they are able to express their emotion, a smile, tear or just a knowing look. I am often asked by one of our residents to 'sing my special song' - we smile, we share a moment and we connect.

It takes a few minutes out of my busy shift but it's a way of feeling connected for her.

My enthusiasm is paid back tenfold.

This is an amazing job and I love it. I really want to give my best and make a difference. The smallest acts of kindest, care, concern or respect create the security and safe feeling we all need. It takes very little to give a lot.

My enthusiasm is paid back tenfold as I go home at the end of my shift feeling that I have been the difference in the day of so many. How many jobs have that impact on us? It's what drives me to do and give more; it's addictive when you realise the impact you have, what you can do and how that will be received.

Is this self-gratification? No. The gratification is knowing that I have an ability many don't recognise or realise exists within them. I love my job; I want to do this, I choose to do this. I don't have the magic touch, I have compassion and that is priceless.

I am so proud to be part of a team that shares my values, my excitement, enthusiasm and sense of fun.

We will probably all get old, be left behind as those we love leave us and will all seek the need for that someone in our day to make us smile, share a song and a moment of connection. I see that in myself and I therefore know it in others.

I am so proud to be part of a team that shares my values, my excitement, enthusiasm and sense of fun about every shift ahead. The stars in my eyes are the sparkle of the fun ahead."

Janet Percy, Care Assistant, Chester Court Care Home

Case study 4: "I'm just a care home nurse"

"I chose this title as that's how people see me: 'just a care home nurse'. But I know that I and my sector colleagues are so much more.

I've worked in the NHS for years and, like many others, I choose to work in social care. I didn't end up here as a last resort or as a desperate attempt to pay the bills. That's the first of many myths of how others see me.

The truth is, registered nurses working in care homes have to be better than the rest. They need to be well-rounded, skilled, knowledgeable and effective. These skills are imperative to deliver good care. Why? Because most of the time you're on your own. In no other sector have I had to make so many decisions - complex decisions - with just one chance to get it right.

In no other sector have I had to make so many decisions.

The multiple comorbidities people live with are often overlaid with poor communication skills as so many of those in our care are living with dementia. Things change on a daily basis, such as a person's responses, but when someone starts to deteriorate rapidly, the skills that come from years of practice of recognising subtle changes in an individual's behaviour, response or demeanour come to the forefront.

The ability to assess those changes and take action is what makes care home nursing so skilled. The longevity in the relationship with residents and investment in building a relationship over time gives us a unique relationship with our patients. The continuity in our care enhances our observation

and assessment skills in a very unique way. It means we see the most subtle changes and can act fast to ensure appropriate and timely intervention. The tipping point and admission to hospital can often be avoided through proactive management of 'crisis'.

We see the most subtle changes and can act fast.

Often there isn't a colleague to consider a dilemma with, or a peer group to turn to, or a rapid medical response, or immediate access to a doctor to consult. Care home nurses have to be 'on their toes' to ensure those in their care get the best.

You can't just be a care home nurse overnight. It is not a job that just anyone can do, you have to have a broad experience to fall back on. You are at the front line when things go wrong so you need experience of multiple condition management, strong clinical decision making ability and assurance and confidence in your practice. Your understanding of accountability and governance is paramount to underpin practice in this field.

Care home nursing is so misunderstood and we are in part to blame for not teaching others about what we do, who we are, the difference we make and the challenges we face. I wouldn't go back to the NHS now. I'm far too skilled and I really believe I would be frustrated not being able to practice with the greatest freedom and autonomy.

This is a speciality where nursing is nursing and there's lots of good practice to share.

If we don't challenge others about their ignorance of our speciality, we only have ourselves to blame and only ourselves to be frustrated with. This is a speciality where nursing is nursing and there's lots of good practice to share.

So, I'm not 'just a care home nurse': I am an intuitive, skilled, insightful nurse. I am skilled, I have longevity in my relationships and knowledge and insight into the needs of those in my care".

Mary Rabbitte, Unit Care Manager, Jewish Care

Case study 5: "Helping new care home managers establish themselves in their new role"

"The care home sector has for some time suffered with a poor image despite the excellence that exists within in it. Like any industry, service or public sector there is good and bad everywhere.

Being a care home manager is not for the faint hearted and the transition from a public sector role to working in the independent sector takes more than a leap of faith.

How can we help people to make that transition?

Problems can arise from these roles being isolated and at times it can be "tough at the top". Buddy schemes for new managers and an induction programme that creates a network of support from peers is crucial to help new managers find their feet.

In larger organisations, home managers have a chance to meet with area and regional managers and peers, but within our communities many managers sit alone in small or single providers. For them in particular the network is crucial, not only to offer support in times of "crisis" but also to share the good work we do.

I am fortunate that my care home is part of the 'Teaching Care Home' pilot programme. This has prompted me to think about learning in our home and how we can share this learning in our community and with others. Being a Teaching Care Home means we are striving to be a recognised beacon within our community and within Methodist Homes.

We aim to be seen as a beacon of good support for newly appointed managers.

Our home is open to visitors from across the sector to share the changes we are striving to make and the culture of learning and continuous improvement we are developing. We aim to be seen as a beacon of good support for newly appointed managers to help them transition into the role, learn about systems, processes, team leadership and home culture and ultimately help them establish themselves in a new role in a very different and challenging environment.

This can be made more difficult by the complexity of the home manager role which is often poorly described or misunderstood.

It's multi-faceted, complex and with a touch of the entrepreneurial about it. Learning about the process and interfaces from the care home perspective with regards to local authority departments, CQC, CCG and local health services is one thing. Internal compliance with new management, budget and governance procedures is another.

Learning how to pace and plan is key.

The home manager role is often a combination of HR, finance, governance, catering, housekeeping, maintenance and PR, with external support in big organisations, but single providers may find they are also their own CEO. Therefore, learning how to pace and plan is key.

The pressures are often great and the clinical and commercial aspects of the role take enormous energy, determination, negotiation and sheer hard work to ensure an efficient safe and effective environment for residents and staff.

Having the ability to spend time with an established manager and gain insight into how a home functions could also be used as an opportunity for learning for potential future managers. At a time when we are struggling to recruit, "growing your own" has never been more needed and we could build capacity within our teaching care home to be a place of learning and a test bed for new career opportunities.

We need to support each other and create networks.

Connecting across our communities is key in sharing the learning, developing skills, and building our future leaders.

We need to support each other and create networks to demonstrate how care home careers can be exciting interesting and changing. With a shrinking pool of talent we have to up our game and offer a new opportunity for the future.

Sustaining the momentum, spreading the word and describing both the challenges and many, many opportunities of working in a care home could help us remind people we are an important part of the health and social care system and a vital part of keeping it going".

Siva Sivanandarajah, Home Manager, Berwick Grange

Chapter 3

Throughout the Teaching Care Home pilot, the International Longevity Centre – UK conducted several interviews with high profile stakeholders from the health and social care sector. In this section, the broad themes of the interviews are analysed and described. The purpose of these interviews was to:

- Monitor awareness of the pilot throughout the life course of the pilot.
- Gauge perceptions on achievements of the pilot, especially relevant towards the end of the pilot.
- Ascertain key learnings to take away from the pilot.
- Gauge perceptions of the wider challenges the care home sector is facing.

The interviewees came from prominent care home providers, regulatory bodies and organisations representing the adult social care sector and care home sector.

Awareness of the pilot

All interviewees were aware of the pilot, but levels of awareness were broad in scope.

Representatives from the care home providers that were involved with the pilot were obviously aware of the aims and objectives, but as they were from senior management, awareness of the day to day working methods of the pilot varied.

Some of the stakeholders from the wider care home sector were aware of the pilot from the Department of Health taskforce on nursing in care homes. Others became aware of the pilot when it was discussed as part of NHS England's plan for people entering nursing homes from urgent care. In these cases, detailed knowledge of the working methods of the pilot was limited. It is hoped that the reports published, and the dissemination involved, will give a more detailed understanding of the pilot.

Perceived achievements of the pilot

All interviewees felt there were positives arising from the pilot, and there were achievements to be celebrated. However, it was mentioned many times that the time frames of the pilot were simply too short to fully assess what the achievements were. One interviewee stated that an achievement of the pilot was “championing that care home nursing is different, specialist”.

What achievement looks like at the pilot's conclusion varied between stakeholders. One person hoped for a positive message to come out from the sector, and it was important that it showed that the sector is continuing to professionalise so that “people feel good about living in them and working in them, which will be positive for recruitment and retention”. This person also said that an achievement would be raising the profile of care homes and nursing homes, more motivated and upskilled staff, the pilots spreading to other care homes and ultimately care homes, and care home providers, “being seen as part of the system, a partner in the health system”. Another stakeholder, who said at the start of the pilot that they “would like to really understand what do individual providers themselves do for recruitment and retention of nurses” thought that the profile had started to be raised, and the pilot had gone some way to demonstrating that care homes can be providing innovative solutions to long term challenges.

One interviewee thought that the pilot, particularly the Berwick Grange pilot, had succeeded from their perspective, in highlighting that it is possible to identify the “hidden talent” that is in the care

home workforce. This was, they thought, their most prominent message to come from the pilot. If the pilot was to continue, they thought that success could continue by developing a template to unlock the talent across the sector so it can be transferred to other care homes. This would be particularly important to enable competent and passionate care workers to become registered nurses. They also stated that an achievement of the pilot was each site strengthened working relationships with outside agencies such as CCGs and hospitals.

One respondent, from one of the care home providers who participated in the pilot, thought the achievements of the pilots were positive on two levels. Firstly, from an organisational point of view, the senior management could learn from the bottom up, which is important for a healthy organisation. Secondly on an individual level, the staff who benefited from the mentoring and training benefited, and performance improved. Beforehand, the pressures staff were under resulted in training being too brief or too infrequent, due to the problems in swapping shifts and general challenges in having enough staff to cover the care home. However, they noted that “the change has been profound”, and is hopeful this will create a ripple effect within the care home. They also agreed with other interviewees that the pilot has put forward a positive vision of care home nursing, which, they hoped, would counter the prevalent bad image it suffers because “people just don’t understand it”.

Key learnings from the pilot and future plans

One person from a care home provider said they were excited about the pilot, and felt it has some great potential in terms of helping carers become registered nurses. They also felt that a key learning was that the care home sector, within itself, can come up with innovative solutions to the challenges providers and local authorities are facing across the country.

Another respondent had initial concerns that the pilot’s working methods were taking too long to be defined, but acknowledged that often that is “inevitable”. They knew that the leadership team within one of the care homes, had received the mentoring, had appreciated it, but they reported that they would have liked more structure and “a bit more of the training”. If the pilot is to continue, these lessons should be acknowledged and learned from. There was also a call for more measurable goals in the pilot, although several interviewees believed the time limitations of the pilot projects, and the funding limitations that lead to the time frames, meant that using defined metrics such as turnover rates and care outcomes would not be viable.

One stakeholder, when interviewed at the start of the pilot, was concerned that the dissemination and communication was “sort of neglecting the digital age”, in terms of the outputs and sharing of learning. The Teaching Care Home pilot did, as it progressed, grow an online presence as the Nursing Times Teaching Care Home microsite became more populated with blogs from those who were participating, and ‘tweet chats’ were held throughout the pilot.

In one interview, whilst discussing the pilot’s aim of raising the profile of care home nursing, it was noted that there are two distinct groups care homes need to attract. Those are newly qualified nurses or those in the early stage of their careers, and those that are returning to the profession after a career break. When asked whether these two groups respond to different incentives, the interviewee thought that interesting further work after the pilots had concluded would be to try to determine whether there is a differentiation in what motivates these two groups.

The interviewee had some ideas based on experience; they thought that newly qualified nurses placed importance on mentorship and training, and thought more could be done within care homes to prove that they are serious about attracting undergraduate nurses. Another stakeholder had similar thoughts, saying “traditionally, the sector falls down on mentoring newly qualified nurses”. In terms of nurses who are returning after a career break, or getting disillusioned with NHS nursing, the interviewee thought there were distinctive things about care home nursing that were attractive. “it’s almost what nursing used to be about”, they said. “You’re not mobbed by doctors, it’s independent, ‘proper’ nursing”.

When discussing the possibility of future pilots, it was highlighted by one interviewee that whilst this was specifically focussing on nursing care, a longer-term approach would include the workforce in residential care. This is, according to this interviewee, because the levels of eligibility to receive nursing care will continue to increase as the number of older, more frail people increases in England. With an increasing number of old and frail people requiring care, they said “we will either need nurses in the residential homes, or a much more highly skilled non-nursing workforce”.

Wider challenges in the care home sector

During the interviews, stakeholders were asked for their ‘top asks’ for policy makers right now in terms of the care home sector. One representative from a major provider simply said “train more nurses”. They continued that an idea could be for rotations to be routinely offered for nurses between the NHS and care homes, presumably to improve communication between the health and social care sector and to improve recruitment rates. Another interviewee raised the importance of dialogue and good working relations between the care home sector and health sector, saying that care homes need to be more involved in the Sustainability and Transformation Plans (STPs), as an efficient care home is vital if health care is to be sustainable. One stakeholder said there was a real need to collaborate with the NHS, to “work out what their different remits are, what their strengths are”. They also called for secondments between care homes and hospitals, as “they both treat the same people”.

One respondent said “I really have to say this – the sector is underfunded”. They were critical of some providers who are not funding their employees’ training. They also highlighted the chronic challenges in terms of gaps in the nursing workforce, and the detrimental effect of having to use agency staff, as it “stunts the workforce when turnover is so high, so transient”.

The financial sustainability of the care home sector was raised many times during the interviews, with many respondents highlighting the workforce pressures this results in. One interviewee said that care homes are concerned about the ending of the nursing bursary, and that care homes need to act now to “future proof” the workforce considering the expected fall in the numbers of registered nurses. They said “we are already competing with the NHS [in terms of attracting nurses]. If the numbers go down 30%, we are in a huge problem”. They said that providers offer good pay to compete with the NHS, but they lack the large structural advantages such as pensions which the NHS can offer.

The same interviewee also highlighted that providers are struggling to adapt quick enough to constantly changing fee structures from local authorities. As local authorities are constantly having to readjust budgets due to unprecedented budget restraints, the fees paid by councils to care home

providers change quickly. This interviewee described it as an “Ebay approach”, with different prices and approaches for each local authority. Large providers working over several local authorities have found it challenging constantly adapting to the changing local financial structures.

There was a sense from the interviews that the care home sector was at a crucial stage, with some fearing they were nearing a financial “tipping point”. Many homes are so financially stretched that any money is going on the basics of the home, such as repairs and alterations, and thus training budgets are even more stretched.

One interview discussed the emerging role of nursing associates within the care home sector, and whether this role can alleviate pressures. Their view was that it was too early to say, but overall the feeling was that it will alleviate some workforce demands in the coming years as “based on the projected figures, everything will be growing in terms of nursing demand and care demand for people who need high level care”. The demographic trends and workforce statistics tell us this, and, in their opinion, “I think the nursing associate role is fundamentally a positive thing if registered nurses can then be released to be professionals, become practice leaders and lead planning and delivery of care provision”.

The same respondent said that their ‘top ask’ would be that when looking to improve the care home sector, the same resources that are available through the health system are available to the care home sector to support the development of nursing. The CPD for nurses, they said, was “currently insufficient”. This was predominately because funding is provided through a health organisation, although there are currently some pilots that share resources, “with varying levels of success”. This person said that “it’s no good just finding the money to fund nurses, you need money to train them up as mentors to be able to grow the workforce”. The interviewee pointed out that there was Government support for first year social workers, and the NHS nurse workforce, but there wasn’t a similar scheme for the adult social care sector.

The perception of nursing in care homes, both within the nursing profession and the wider public, is generally perceived to be poorer than NHS nursing, and this was acknowledged by many interviewees. One said that the most important thing this project should challenge was the image of nursing in care homes. They said, “we need people with skill, decision making abilities and empathy. It’s not a job where you just do a medication round and retire... Nursing is only going one way in care homes, it’s becoming more complex”. They also felt that although nursing recruitment and retention is the biggest priority within the sector, they are hopeful this pilot and others will go some way to attract other medical professionals into the care home sector.

A Teaching Care Home pilot



Additional outputs from the pilot

Tweet chats, vision statement and
education and development framework

April 2017



Additional outputs from the pilot

This section includes additional outputs that arose from the pilot. Included in this section are:

- Summaries of two tweet chats hosted by the Foundation of Nursing Studies.
- The Teaching Care Home Vision Statement, which was informed by these tweet chats and subsequent roundtable discussions.
- A framework for education and development in a Teaching Care Home, produced by Manchester Metropolitan University.

Chapter 1

Tweet chats and the co-production of a Teaching Care Home Vision Statement

The Foundation of Nursing Studies hosted two tweet chats to discuss with leaders in the care home sector what the vision of a Teaching Care Home should be. Participants were able to share ideas, debate and ultimately help co-produce a vision statement of a Teaching Care Home. Additional roundtable discussions were held with the pilot participants, where the vision statement was further refined. Below, we have included the discussion summaries of these tweet chats, followed by the final vision statement of the Teaching Care Home pilot.

Summary of the Teaching Care Home Tweet Chat, held 10th January 2017

Person-centredness is:

- Recognising individuals:
 - Their uniqueness
 - Their diversity
- Underpinned by values – working with the person – in partnership – to understand what matters to them. Their:
 - Values
 - Aspirations
 - Preferences
 - Circumstances
 - Role in the community
- Respecting the individual by enabling/supporting them to 'be normal, to 'be themselves', without judgement
- Focusing on the strengths and needs of an individual to facilitate self-care and shared decision-making – holistic care planning
- Treating the person with dignity, compassion and politeness (in a way that you would like a member of your family or yourself to be treated)
- Enabling choice
- Noticing emotions and acting on them

Person-centredness should be a key feature of a Teaching Care Home because:

- As a key principle of nursing practice (Manley et al., 2011), person-centredness should be the cornerstone of care in any setting and should underpin everything we do
- People go to care homes to live – they are not living in our workplace, we are working in their home

Person-centredness can be realised for residents and staff by:

- Working with residents
 - Asking residents about what matters – first step and every step
 - Asking the right questions
 - Creating connections between residents and staff
 - Assessing risks
 - Helping to make informed choices
 - Enabling/taking action
 - Acting as advocates
 - Adopting a strengths based approach
 - Using of care planning and tools appropriately e.g. assessments, one-page profiles
 - Paying attention to the importance of ‘little things’
 - Remembering you are a ‘guest’ – it changes dynamics
- Creating supportive cultures
 - With person-centred leaders and role models
 - Where staff:
 - Feel valued and heard
 - Have time to care
 - Have opportunities to reflect on practice e.g.
 - Why we do what we do?
 - Sharing positive practice stories
 - Which recognise/celebrate person-centredness
- Recognising the complexity of care and developing an appropriately skilled and competent workforce
 - Developing a support and education structure through:
 - Strong links with universities
 - Access to training, supervision and wider development opportunities
 - Support for education and mentorship
 - Access to wider networks
 - Being involved in research
 - Acknowledging and celebrating the role of the RN
 - Recognise the role as different, diverse, challenging and requiring complex skills
 - Promoting care home nursing as a positive career choice
 - Celebrate the autonomy and opportunity to build relationships with residents
 - Developing a better understanding of the role of the RN
 - Introducing staff rotation between care homes and acute and community services
 - Increase student placements in care homes
- Celebrating the work of care homes
 - Creating local forums
 - Building relationships with local press
 - Engaging commissioners

We can evaluate person-centredness in care homes by:

- Asking:
 - Residents
 - Families
 - Visitors
 - MDT
 - Staff
- Communication amongst stakeholders
- Using available models

Summary of the Teaching Care Home Tweet Chat, held 2nd February 2017**In an effective learning environment in a care home:**

- All staff, residents and even relatives contribute to and benefit from learning
- Learning happens in the care home – not just in classrooms
- Registered staff have expertise that is valued; they are visible and involved in care – acting as role models
- Staff are motivated to:
 - Maintain their own education
 - Facilitate the education of others through coaching, challenging, showing and telling whilst working
- There is a positive approach to learning – questions and curiosity are:
 - Welcomed with openness and enthusiasm
 - Embraced
 - Encouraged
- Visible signs of learning are evident:
 - Posters, leaflets and other information on display
 - Journals and books
 - Internet access

Effective learning environments can be created in care homes by:

- Seeing the care home as the key learning environment – using it as the main resource for learning, recognising the teachable moments
- Having proactive staff/team:
 - Confident to teach others
 - With mentorship skills
 - Who can adapt to different learning styles
- Support from wider education providers and/or MDT team
- Structured programme/plan of learning (education and training)
- Standards
- Access to resources:
 - Staff time
 - On-line training
 - Wider resources e.g. MyHomeLife online tools etc.
- Evaluating learning e.g. audit, assessing behaviour change

Good leadership is essential to enable learning in a care home. A leader should:

- Be committed to person-centred care
- Be committed to staff development
- Lead by example – act as a role model
- Facilitate learning
- Be accessible
- Be visible
- Be involved in care
- Have clarity of direction
- Listen to others
- Inspire and empower staff to make decisions
- Facilitate time and opportunity for learning and development
- Celebrate good care/success

Care home nursing should be recognised as an excellent career choice as these nurses:

- Provide increasingly complex care
- Require multiple competencies and skills
- Need to work autonomously
- Can learn and develop and support the learning of others
- Enable the creation of places to live and die well by:
 - Getting to know the residents, their families and the community
 - Seeing the whole journey

Care home nurses should be proud of and promote the positive work they do to:

- Celebrate their good work
- Create interest
- Gain respect
- Change perceptions

Care homes can provide excellent opportunities to learn and develop and enable the development of others (including team working, continuity of care, relationship centred care, advanced practice, complex care, dementia, disabilities, end of life care, and extended clinical skills) **for:**

- Care home staff
- Student nurses
- Return to practice nurses
- Allied health professionals

Student nurse placements in care homes should be promoted and increased:

- With universities by raising the profile of what care homes are all about and why they are valuable placements
- With student nurses by raising the profile of what care homes are all about and how they could be an excellent career choice

- With care homes by profiling the advantages of student placements for care homes e.g. contributing to the learning environment, providing future workforce
- By active engagement between care homes and universities – in-reach and out-reach – a two-way process:
 - To secure placements
 - To prepare staff e.g. mentorship and wider learning opportunities

Wider opportunities for care home nurses should be developed:

- Signposted career pathways
- Clinical academic careers with NIHR

Integration of care homes with wider communities and health and social care is important to:

- Enhance understanding of care homes
- Enhance sustainability and improvement
- Facilitate the integration of care homes within the health and social care community
- Create shared learning opportunities/resources
- Facilitate the development of new models of care
- Facilitate the seamless transfer of care between providers

Chapter 2

The final vision statement for a Teaching Care Home is:

A Teaching Care Home: Vision Statement – April 2017

Teaching care homes demonstrate an ongoing commitment to person-centred care and ways of working, which will be experienced by all who live, die, visit and work in the home. They are centres for learning, practice development and research, actively engaging with staff, students, residents and the community. They have strong working relationships with academic and education providers and are a resource for other care homes.

Residents and relatives will experience person-centred care in a home that:

- *Has comfortable personal and communal spaces*
- *Feels safe and has a friendly atmosphere*
- *Recognises the uniqueness and diversity of individuals by:*
 - *Understanding what matters to them*
 - *Respecting and supporting their dignity and privacy*
 - *Supporting and enabling personal choices and decisions*
- *Nurtures and maintains healthy, caring and empathic relationships*
- *Is part of the local community and embraces partnership with others to create a holistic care experience for the resident.*

There will be:

- *Person-centred leaders and role models who are visible, accessible and involved in care*
- *A spirit of working together as a team, having a sense of well-being and benefiting from a commitment to learning and development for all*

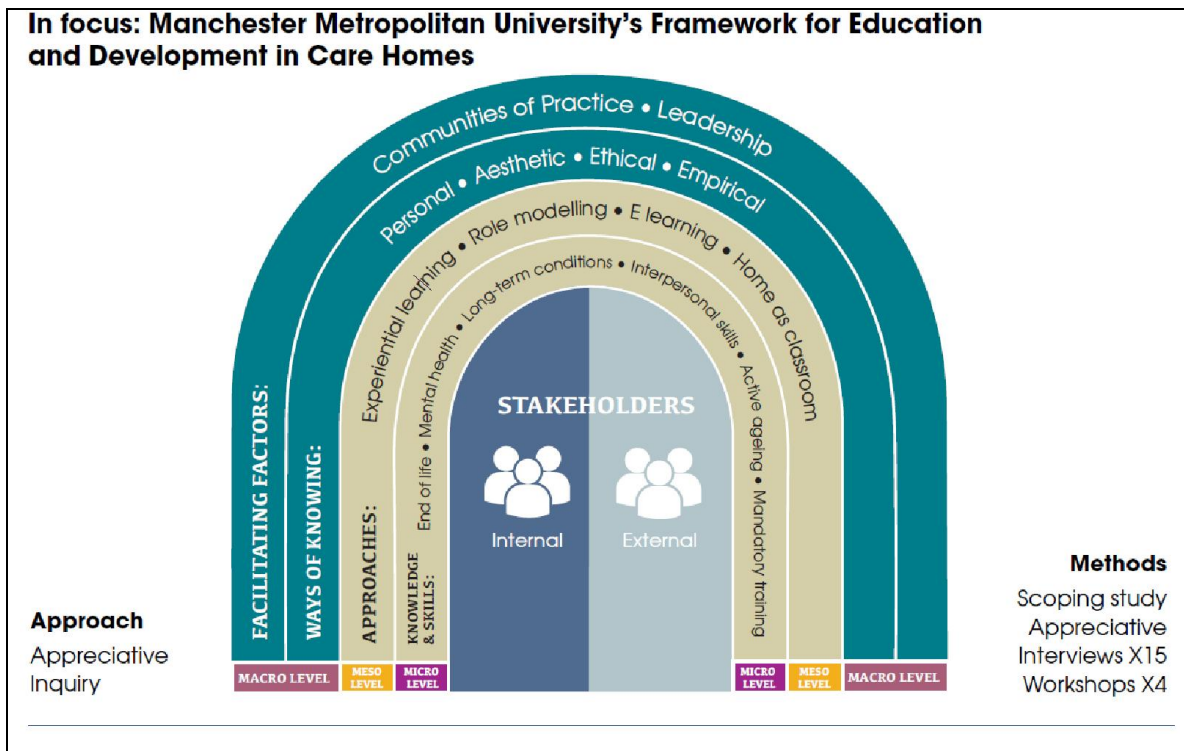
- *A team that feel:*
 - *Supported, listened to and have a sense of worth*
 - *Their learning and development is a priority*
 - *Engaged and enthusiastic, able to think and act independently and with confidence*
 - *Proud of and celebrate the good work that they do*

The teaching care home (with support from the provider organisation) will:

- *Ensure appropriately skilled and competent permanent staffing to provide person-centred, safe and effective care*
- *Support the development of a positive learning environment providing both workplace learning and formal education and training (informed by individualised learning and development/career pathways that are consistent, robust and flexible to meet the needs of both staff and residents)*
- *Forge partnerships with academic and education providers to:*
 - *Promote and increase student nurse, apprentice and other MDT placements within the home*
 - *Provide access to learning and development opportunities for staff, including mentorship training*
 - *Become active participants in practice development and research*
- *Support and enable positive and effective communication within the home*
- *Facilitate the integration of the care home with wider communities and health and social care partners and stakeholders*
- *Actively promote the positive work that care homes do*

Chapter 3

The framework for education and development in care homes



Through appreciative inquiries, scoping studies, workshops and interviews, Manchester Metropolitan University produced a framework to use to deliver effective education and development in care homes. The framework is illustrated below, with explanatory text.

The overarching aim of the framework, illustrated previously, is to support thinking about, and enhance understanding of, the education and development of nursing staff working in care home settings. Through the research we have been able to identify good practice and the conditions under which it thrives, and these findings have been at the heart of the framework development.

The 5 framework domains are of equal importance and can be broken down into further detail.

Facilitating Factors

The Facilitating Factors are the overarching conditions in which effective education and development take place. These include effective Leadership and Communities of Practice. The data suggests that transformational leadership was viewed as the most effective style to support the development of care home staff. Networking and sharing good practice was viewed positively as a way to develop and support staff in care homes, who might sometimes feel isolated in their roles.

Ways of Knowing

Based on the work of Carper (1978) these are the fundamental ways of knowing in nursing practice: Empirical, Aesthetic, Personal and Ethical. The respondents in this study described multiple ways of knowing to guide their work with residents in the care home setting.

Learning Approaches

These are the multiple methods used to support education and development in care home nursing and include; experiential learning, role modelling, E-Learning and 'Home as Classroom'. Along with formal 'methods' some approaches were described as more informal, such as role modelling, which happened opportunistically in the care home setting. Staff wanted to learn in ways, which recognised their different learning styles and were flexible in their approach, for example, for staff working night shifts.

Knowledge and Skills

This describes the knowledge and skills required to support care planning and delivery in the care home. This list is not exhaustive although based on the scoping study and research data these were the most common aspects, which support effective care in the home: end of life, mental health care, long-term condition management, mandatory training (including, for example, fire safety, infection control and moving and handling), interpersonal skills and support of independence and active older age.

Stakeholders

It is important to consider the requirements and views of the various stakeholders who are involved in the care home setting. These are both internal to the home, for example, residents, families, staff and care home managers, and external to the home, for example, care home owners, regulators and other agencies such as primary and acute care services. Each has a different but important interest in the promotion of quality, which occurs when staff are educated, empowered and supported.

A Teaching Care Home pilot



Summary impact of the ‘Teaching Care Home’ pilot

April 2017



Summary impact of the ‘Teaching Care Home’ pilot

For the full impact report, please see the booklet entitled: A Teaching Care Home: Impactful, Inspiring, Informing

At the start of the Teaching Care Home pilot, these objectives were set. Below we assess whether these objectives have been met to date.

To deliver five nationally prominent centres of innovation, each set up in an existing care home and spread geographically across England.	✓
The development of the draft vision and educational framework which will guide the homes towards achieving the status of a TCH.	✓
To improve the image and visibility of care home nursing to undergraduate nurses and across wider spheres.	Too early to judge.
To provide learning opportunities and structured Continuing Professional Development to nurses in the sector.	Learning opportunities were enhanced but structured CPD was only considered in Berwick Grange. Good progress is being made.
To create an environment where innovative solutions are tested to address the key challenges faced by the adult social care sector.	On its way to being met.

Did the pilot meet its primary objectives?

1. To deliver five nationally prominent centres of innovation, each set up in an existing care home and spread geographically across England.

At the pilot start, five care homes were selected from five prominent care home providers. There was a good geographical spread, which was important to the pilot coordinators. These centres of innovation are based in Northumberland, Gloucestershire, London, North Yorkshire and Greater Manchester.

2. To improve the image and visibility of care home nursing to undergraduate nurses and across wider spheres.

This is the most difficult of all the objectives to determine success. This is mainly because the pilots are still ongoing at the time of writing, as well as the difficulties in determining the overall image of the sector in the eyes of undergraduate nurses. The subsequent engagement after this report publication will also be crucial to this. However, over the course of the pilot timeframe, pilots were cited in several conference speeches to the care home sector. Wider stakeholders, including Health Education England, NHS England and prominent national organisations in the health and social care sphere were engaged through a series of telephone interviews, which went some way to raise the prominence of the Teaching Care Home pilot. Further parliamentary engagement is planned, to raise the prominence of the sector and especially nursing in the sector, at the publication of this report. It is therefore too early to definitively evaluate any changes to the image and visibility of care home nursing to undergraduate nurses and across wider spheres.

3. To provide learning opportunities and structured Continuing Professional Development to nurses in the sector.

All care homes have enhanced the learning opportunities for care staff. The Foundation of Nursing Studies has provided a programme of support including six workshops, site visits and mentorship. Registered nurses and care home managers also received 1 to 1 telephone coaching. This support has helped participants to develop their knowledge, skills and confidence in leading the creation of new learning opportunities for staff and facilitating practice improvements. Further developments will be supported by the draft vision and the education and development framework.

4. To create an environment where innovative solutions are tested to address the key challenges faced by the adult social care sector.

This objective is on its way to being met. From discussions with participants of the pilot in all the care homes, an environment has been created to encourage innovative thinking. Many staff have discussed their increased confidence in their own ability to assess the challenges faced by the sector, and how they are the ones who are often best placed in their organisation to develop innovative solutions. It has been encouraging and inspiring to witness the personal development of staff throughout the pilot. If the structures that have been implemented continue to be implemented, such as regular allocated time to reflect on the challenges they face at work or improved dialogue and knowledge exchange with local universities, this will continue to foster innovation. However, this objective must be judged to be on its way to being met. This is because some of the pilot schemes created by the care homes are still ongoing, or about to be fully implemented. It is therefore unfortunately too early to determine success, although early indicators are encouraging.

Summary of final outcomes and outputs Activities within the care homes

Outputs

Rose Court	Berwick Grange	Chester Court	Millbrook Lodge	Lady Sarah Cohen House
Workshops and 1 to 1 support to introduce staff to the concept of reflective practice and how to develop their skills. Formalised time and structures to encourage staff to regularly reflect on their work: 'what do we do and why do we do it?', to learn and share.	A fully developed career pathway for non-EEA care workers who are nurses in their country of origin to become registered nurses in the UK. Pathway includes tailored tutoring course on improving spoken and written English. Mix of online and face to face learning. Increased connections with Harrogate college, three health and social care students taken on placement.	An approach to nutrition which is more person-centred and responsive to needs and desires of residents. Meal times that were more flexible, and an alternative cold menu which is available at any time of the day. Staff who had expertise in dementia provided training for other staff on the specific challenges regarding dementia and nutrition.	Stakeholder group established and meeting regularly, involving the acute health and social care sectors. Adaptation of Sutton Vanguard project 'red bag' initiative to local context. Development of a checklist of medication, personal belongings etc. for all residents being admitted to and discharged from hospital.	Workshops to explore what it is like to work in the home and ideas for improvement. A smaller meeting between carers which allowed them to share ideas and working practices.

Outcomes

Rose Court	Berwick Grange	Chester Court	Millbrook Lodge	Lady Sarah Cohen House
<p>Staff who were involved reported increased knowledge, skills and confidence in using reflective practice to improve their work.</p> <p>Staff also reported increased confidence in their ability to carry out their work.</p>	<p>Staff report a change in atmosphere and staff morale.</p> <p>A carer who was a new member of staff is applying for a nursing degree, due to the environment of working in a Teaching Care Home.</p> <p>Too early to record outcomes from overseas nurse development pathway. Seven care workers are about to start the programme.</p>	<p>Increased contact and liaison with the Vanguards in Gateshead/Sunderland.</p> <p>Staff have reported improved weight gain in residents.</p> <p>Improved staff morale, with points scheme introduced to reward staff who 'go the extra mile'.</p>	<p>Improved dialogue between local hospital and care home.</p> <p>Increased contact rates between care home and hospital and CCG.</p> <p>Red bag scheme to be built into care pathway.</p>	<p>Staff who were beneficiaries of the pilot self-reported that they appreciated the time spent together and improved team work and communication.</p> <p>Following the workshops with staff it was recognised that regular team meetings were needed to enable staff to share ideas and discuss issues.</p>

In focus: Manchester Metropolitan University:

Role in pilot:

Educational Researchers.

Specific activities:

Undertook Scoping Study, 15 qualitative interviews with a range of nursing staff, 4 workshops with care home staff.

Hard outcomes:

Production of a Scoping Study; Data analysis of interviews and workshops; Development of Education Framework to support learning in care homes; Recommendations for future practice.

Presentation of research at Royal College of Nursing Education Conference, Cardiff City Hall, March 2017.

Soft outcomes:

Positive feedback from participants who took part in the research.

Learning for future:

Some important findings, which arose from the research included;

The need for effective leadership in the care home setting, to role model good practice and support staff development.

The value of communities of education, within and across homes, to share good practice and provide support to care home nurses.

The need to identify and utilise flexible and innovative learning methods, which appeal to the different learners in the care home setting and to value the care home itself as a valuable developmental area for staff.

Legacy:

Education and Development Research Report.

An Education and Development Framework for Care Home Nurses, which included multiple factors to support thinking about this aspect of practice.

In focus: The Foundation of Nursing Studies:

Role in pilot:

Throughout the pilot, FoNS has worked closely with the five care home teams, helping them to develop knowledge, skills and confidence to work in their homes, with their colleagues, to strengthen the culture of care and the learning environment. This has involved the development and facilitation of a workshop programme, mentorship and on-site visits to support the planning and implementation of an innovation within each care home.

FoNS also led on the development of a draft vision for a Teaching Care Home. This process started with the care home teams, but then involved a wider engagement process through two tweet chats, three roundtable discussions and a final invitation to comment through appropriate networks. Participants have included health and social care staff, university staff, residents, CCG staff, care home providers.

Specific activities:

6 workshop days; 3-4 site visits per care home; 4 blogs reporting on/profiling aspects of the work; 2 tweetchats; 3 roundtable discussions.

Hard outcomes:

A draft vision of a Teaching Care Home

Soft outcomes:

Positive feedback from care home teams about the impact of participating in the programme. For example: developing greater insight into person-centredness and how this might impact on care and staff relationships; the value of reflection as a means of learning in and from everyday practice; becoming more aware of the importance of learning for all staff, both formal and informal; enhanced confidence about their roles within the care home and the fact that they were doing a good job; recognition of the need to engage with staff in more meaningful ways so that their views and perspectives feel heard.

Raised profile of good quality care home nursing through sharing of activity through social media.

Learning for the future/future actions:

Further work needs to be undertaken to refine the focus of the draft vision, strengthening the emphasis on learning and research.

Participants need support to reflect on their learning in a way that can be shared, enabling their care homes to become a resource for others.

Relationships between care homes and academic and educational organisations should be prioritised and strengthened to enhance opportunities for both learning and research.

The need for organisational support should be strongly emphasised. For example, organisations making a genuine commitment to facilitating the participation of staff and supporting the creation of learning environments within the homes.

Legacy:

Any legacy is tentative at this stage. If additional funding is secured, the number of care homes involved could be increased, helping to further develop the Teaching Care Home concept, with the ultimate aim of creating a network of care homes that offer excellent care and learning opportunities and who act as a wider resource across the care sector.