Workforce requirements for healthcare in care homes

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In this breakout session you will have an opportunity to:

• Hear a summary of the findings from a qualitative study of the experiences of practitioners, social care officers and carers involved in the Gateshead enhanced healthcare in care home programme

• Explore models for workforce development adopted for the Gateshead enhanced healthcare in care home programme

• Share with other participants service and workforce developments that are occurring in your own localities to enhance health care for care home residents

• Reflect on the issues and challenges to integrated working between NHS, social care and care home services.
Aim and objectives of the research

To explore the experiences and competencies of the current Gateshead Care Home workforce team through:

– Exploration with staff and carers who have been involved in the Gateshead Care Home Project, of their own experiences of delivering care, the knowledge, skills and competencies required to deliver this care, their views on their development needs and the barriers they face in everyday practice

– Assessing the current, potential and projected workforce competencies required to deliver the Gateshead Vanguard service delivery model in the care home sector
Who did we talk with for the Gateshead programme evaluation?

Focus groups - total participants: N= 37

• Care home staff
  – N=11: 10 F/1M
  – 2 managers, 2 deputy managers, 1 clinical lead, 1 staff nurse, 2 senior carers, 3 care assistants
  – 9 between 1-5 years in current role; 1: 6-10 years; 1: 10-20 years

• NHS staff
  – N=19: 16F/3M
  – 10 nurses, 4 GPs, 2 consultants, 1 therapist, 2 managers
  – 5 < 1 year in current role; 6: 1-5 years; 2: 6-10 years; 3:10-20 years; 1: 20+ years

• Social services staff
  – N=7: 5F/2M
  – 4 Assessing officers, 2 social workers (adult), 1 social worker (mental health)
  – 2-10 years in current role; 3:10-20 years; 2: 20+ years
Complexity of need of residents in Gateshead Care Homes

‘We’re looking after people with so many multiple needs that you’ve got to weigh it up all together all the time. That we can’t treat by the exact NICE standards for blood pressure and NICE standards for this, because they all conflict with each other and there’s 26 of them and they’ve got 92 problems and 43 medications. So we have to be really pragmatic all of the time. It helps to have a group of people who understand that pragmatism that you need with this complex group of patients working together. It helps not doing that in isolation....There’s no guidebook for all this to tell you what to do.’

- Female
- Age (80+)
- Caucasian
- Multimorbidity
- Comorbidity
- Cognitive impairment
- Frailty
- End of life
Enhanced health infrastructure for care home residents

Linked GP
Sharing of information
Continuity of contact care
Continual review and modification of care and treatment

Nursing home team

OPNS
Enhanced health infrastructure for care home residents

MDT (Community geriatrician, Old age psychiatrist, SALT, Occupational therapist, Physiotherapist, Dietician)

Linked GP

Nursing home team

OPNS

Healthcare economy

Community nursing team

Urgent care team

Intermediate care team

Pharmacy

Social care

Social workers

Assessing officers

Aids and equipment
‘This is a gentleman who has been unwell for the past 4-6 weeks. He’s had a UTI and was admitted to hospital for it. We’ve given him antibiotics in the care home for 3 weeks now. He has not responded to this treatment. I have just had a message from the OPNS to say that he’s still unwell and his last urine specimen indicated that this is only sensitive to a particular medication. So in the past this situation may have led to an admission. But through discussion with the consultant geriatrician I might be able to just arrange for him to just go and get a stat dose of the drug and then go back to the home. So that has prevented an admission........I also know this man. He has dementia and depression. A stay in hospital, if it can be prevented would be a lot better for his mental health also.’
Integrated working across sector boundaries

‘Somebody with a blood transfusion - it would have just been a case of admitting them, but we had a plan to see that they’d go to the day hospital, have a couple of units of blood, and straight back again... And it meant the resident wasn’t admitted.’

‘We had one lady who was going into hospital every week. [OPNS], though... [OPNS], again. She got us trained where we can put a catheter into the bowel, and just drain that. And now the resident doesn’t go into hospital, at all... I think, this has made a massive impact on this residents’ quality of life.’
Consultant: ‘xx had seen him and was worried about his mood. I went in and said no this is part of his apathy to do with his dementia. I didn’t have to catch up because I knew him. All the information is staying together and being used more holistically than before.’

OPNS: ‘A care home manager rang up and wanted to ask one of our wards about a resident who had been admitted. They knew her really well and had a wealth of information about her. The nurse was told “you’re not a relative, we can’t tell you anything.”’
Providing effective personalised care through effective knowledge exchange

‘Knowing the person’
Biographical knowledge

‘Knowing how the person reacts to illness’
Patient knowledge

Biomedical knowledge

‘Knowing the system’
Structural knowledge

‘Interpreting both patient and professional understandings’
Communicative knowledge
Aim and objectives

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Adopting a workforce development approach
What is workforce development?

- “...a multi-faceted approach which addresses the range of factors impacting on the ability of the workforce to function with maximum effectiveness in responding to.....problems. **Workforce development should have a systems focus.** Unlike traditional approaches, this is broad and comprehensive, targeting individual, organisational and structural factors, **rather than just addressing education and training of individual mainstream workers**”.

  (Roche 2001)

- ‘**Workforce development is a holistic concept that integrates workforce analysis and planning, human resource management and capability development** to strengthen organisation success by aligning the workforce to both current and future service demands.’ (Staron 2008)
From our findings, which approach appears to dominate the care home sector?

**Training**
- **Aims**: improve skills
- **Delivery**: usually in-house training in practice setting
- **Assessment**: of skills, (do it this way) often non accredited, not transferable to other settings
- **Concern**: does not focus on rationale for practice or enable practice development

**Education**
- **Aims**: improve knowledge and skills
- **Delivery**: often within universities or colleges
- **Assessment**: of learning-(do you know this?) focus on knowledge acquired, often credit bearing
- **Concern**: no strong evidence that learning is applied in practice (Griscti & Jacono 2006)

**Workforce Development**
- **Aims**: to improve competence, knowledge and skills
- **Delivery**: practice based learning which is academically accredited
- **Assessment**: achievement of competence and academic outcomes
- **Concern**: how can this be achieved? needs to be systems based and strategically supported
Workforce Development is about...

- Individual development
- Knowledge and skills to fulfil a defined workplace role
- Person centred care
  - Ability to understand and respond to need
- Enabling practice development
  - Making a positive difference to the client
  - Changing the context & culture of practice
  - Enabling staff to deliver on commissioned service standards & specifications
- Accreditation of knowledge skills and abilities relevant to role
- Authentic work based learning and assessment
- Adult learning approach
- Helping organisations meet their KPIs

Enhance individuals career chances and salary

(McNall 2012)

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Using a workforce development approach (McNall 2012)

**Start by analysing**
- Build in WFD requirement in future commissioning specifications
- Map existing workforce to competency framework - gap analysis

**Commissioning Spec**
- Identify Knowledge, skills competencies required of current & future workforce KPIs
- Collaboratively developed competency frameworks
- Sets benchmark for agreed competencies

**Informed by critical analysis/future proofing**
- Prevents individuals “jumping through hoops”
- Recognition & accreditation of prior learning
- Pragmatic solutions
- Practice based learning? Technology enhanced learning?

**Using a workforce development approach (McNall 2012)**

**Requires effective facilitation**
- Who will assess competence? Who will accredit prior learning?
- Effective stakeholder collaboration to explore /develop solutions

**Influence strategic educational commissioning**
- Innovative models for workforce development & capacity building
- Effective stakeholder collaboration to explore /develop solutions

**Plan evaluation from multiple perspectives**
- Did we get it right? What are the outcomes for patients, staff, services?

**Sustainable solutions**
- Funding

**Maintaining quality**
Gateshead Vanguard research findings: core competencies required of the care home workforce

- Person /relationship centred care (high quality evidence-based personal care)
- Comprehensive assessment skills
  - comprehensive geriatric assessment including functional assessment/ frailty
  - ‘knowing the person’: preferences, norms and behaviours
  - ongoing and continual assessment
  - early recognition of change/ deviations from the norm
  - Use of tools eg. NEWS/ Gait speed/ Timed up-and-go test/ PRISMA 7 etc.
- Preventative rather than reactive model of care (care planning, enablement, rehabilitation, recognising deterioration and early intervention)
  - Decision making for complex care
  - Managing multimorbidity including polypharmacy
  - Identifying and managing frailty
  - Multimorbidity + Comorbidity (including dementia care) +/or Frailty
  - Referring to other agencies/services and managing transfer of care
  - Record keeping
- Interventions to address totality of health & social care need (should be agreed and standard across care settings)
- Evaluating outcomes- amending the plan of care
- Interpersonal and leadership skills
More than practice specific competencies needed …..

‘It’s having the personal knowledge of that staff team. So if you know that 3 weeks ago they were able to well-manage a similar situation you would feel more confident in trying out that again.’

‘Even within the same care home when different carers are on duty you’ll get different quality of referral...some carers will give you a set of observations and quite a clear idea of what they think is going on....others carers will actually completely miss the unwell person.’
Gateshead Vanguard research findings: Attitudinal competencies underpinning effective care (shared culture, working effectively across the system)

- Valuing older people
- Knowing each other
- Establishing trust (creating confidence in ability to recognise deterioration and provide competent care)
- Valuing each others knowledge and skills
- Empowering each other
- Translating (informing, explaining, teaching, sharing)
- Anticipating need
- Knowing what to do/what is required
- Being flexible/adaptable
- Being prompt
- Following through (delivering care required)
Gateshead Vanguard research findings: Frequently required competencies

- Managing exacerbation of chronic disease
- Managing changes in functional level
- Managing confusion and delirium
- Managing dual diagnosis
- Palliative care
- Safeguarding

Gateshead Vanguard research findings: Competencies to meet specific client need

- Individualised care
  - e.g. PEG feeding
- Specialised care
  - Palliative care relating to specific conditions
- Challenging behaviour
- Managing disability, communication and mobility problems and sensory impairment
The notion of competency

Do competencies refer to
• What we do?
• What we know?
• How we do it ?

• How do we become competent at something ?
• How do we KNOW someone is competent?

Skills

Knowledge

Attitudes
The word **competence** is often used to refer to the ability to undertake tasks. It is important not to confuse **occupational competence** and ability to undertake a task. They are not the same thing.

- Occupational competence is about applying knowledge and skills to achieve a work function. Measuring pulse or respiratory rate is a skill. Assessing deterioration from the norm in a person's condition is an occupational competence. You need one to do the other, but they are not the same thing.

- Is knowledge and understanding required? Do workers need to know why changes in vital signs indicate deterioration?
How do we become occupationally competent?

- Reflection
- Reading
- Practice
- Being shown
- COURSES
- TALKING
- OBSERVING OTHERS
- Feedback from others
- Learning from mistakes
- E learning/ video clips
Gateshead Vanguard research findings: How is competence developed/maintained in the care home sector?

Transfer of tacit knowledge through regular personal contact, interaction and trust

Work-based

Tacit knowledge

Reflection

Role modelling

Formal courses

Training events

Learning through the MDT

Learning from specialists
Gateshead Vanguard research findings: Who assesses occupational competence in the care home sector?

‘…if we’re working into another sector, we cannot sign off those nurses or carers as competent, because our… We are only covered by health…..’

‘You’re covered by your organisation. So even if it was in a different ….health organisation, you wouldn’t be able to sign that they were competent.’
Knowing someone is competent

This person ............

...does always 

...does usually

...does often

...does partially

...does sometimes

...does seldom

...is thought to have done

...does has done

...can do

...will do

...did once

...could do

...may do

Shades of Competence (Race 1994)
Proficiency

- **Proficiency**, comes from the Latin word *proficere*, meaning "accomplish, make progress, be useful."
- If you have *proficiency* with something, you have underpinning knowledge, skills and understanding (occupational competence) and can apply these in different contexts (transferability).
- Proficiency is dependent on situated knowledge, informed by not only theoretical understanding but also experiential and tacit knowledge developed and applied in the practice context (Eraut 1997).
- You can demonstrate your proficiency through assessment
Demonstrating proficiency

- Increasing public concern about the competence of health & social care professionals
- Greater emphasis is now being placed on the valid and reliable assessment of the top two layers of Miller’s pyramid shows how and does
  - Council for Healthcare Regulatory Excellence (CHRE, 2011)
## Principles underlying good assessment

### Validity
Validity in assessment relates to whether the method of assessment actually measures what it seeks to measure—a valid assessment would consider the domain or competencies it sought to assess and ensure that it measured those areas. Needs to assess the integration of multiple competencies and knowledge which practitioners need in order to practice safely and effectively. **This requires a move away from assessing single aspects of a student performance e.g. knowledge, towards assessing applied competency using authentic methods either in the workplace (in-vivo) or during simulation scenarios / objective structured clinical examinations (OSCE) (in-vitro).**

### Reliability
Reliability relates to the degree to which an assessment consistently measures what it measures (McCoubrie, 2010) and relates to the reproducibility of the assessment results consistently between assessors and across samples of assessments—*it can be improved by agreeing the criteria you are assessing against and careful preparation of assessors, by having multiple assessors and triangulation of scores.*

### Practicality
How practical or usable are the assessment methods / criteria involved? Do they fit the context? Are they sustainable? Is this a cost effective method?

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**How can valid & reliable assessment of proficiency be practically enabled in the care home sector?**
Gateshead Vanguard research findings: What are the barriers to developing / maintaining proficiency?

- Variation in availability of and access to training/education across the care home sector
- Agency staff
- Getting backfill/ cover
- Night staff
- Training courses- no assessment of competence
- Asked to work extra hours to attend training- impacts benefits
Gateshead Vanguard research findings: How is proficiency maintained in the care home sector?

Proficiency

- Confidence
- Competence
- Knowledge

Updating requirements

Use it or lose it

Proficiency

Responsibility & accountability for maintaining proficiency?
Gateshead Vanguard research findings: Whole workforce approach: developing competency frameworks

The study identified the need for clear definition of competencies required at 3 levels of practice, not specific to role/ discipline for those;

- Providing direct care
- Working at the level of specialist practice
- Working at the level of advanced practice

This work is underway at present, linking competencies directly to the pathways of care being developed
Developing competency frameworks & assessment methods

Competency Frameworks

✓ Are best developed via effective partnerships between regulatory, educational and practice settings & other stakeholders where necessary (Anema & McCoy 2010)

✓ Should encompass the practice related competencies and underpinning knowledge (expressed as learning outcomes) required for proficiency (Coonan 2008)

✓ KNOW, KNOW HOW/WHY, SHOW HOW- knowledge, understanding, application

• Contemporary assessment regimes for specialist practice & above should certify both;
  ✓ Current performance competencies within a broader framework of graduate level ability
  ✓ The capability of the practitioner to think critically and develop higher levels of understanding needed to develop their practice (Eraut, 1997)
Breakout groups

Groups one, two, three

• What are the key challenges you are currently facing in relation to
  – enhancing health care for care home residents in your own locality?
  – integrated working between NHS, social care and care home services?
• What service development, innovation or transformation are you doing to
  address these challenges?
• What is working and how do you know this?

Groups four, five, six

• What are your current and future challenges regarding workforce
  requirements?
• What approaches to workforce development are you adopting to address
  future service requirements?
• What is working and how do you know this?
### Acknowledging entry level-Regulated Qualifications Framework (2015)

<table>
<thead>
<tr>
<th>Entry</th>
<th>Entry level award, cert, diploma /Skills for life/ functional skills</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>GCSE (grade D-G), NVQ <strong>level 1</strong>, BTEC award, cert, diploma level 1, functional skills level 1, foundation learning level 1</td>
</tr>
<tr>
<td>2</td>
<td>GCSE (grade A*-C), <strong>level 2</strong> key skills, NVQ, skills for life, higher diploma BTEC award, cert, diploma</td>
</tr>
<tr>
<td>3</td>
<td>AS and A level, international baccalaureate, <strong>level 3</strong> key skills, NVQ advanced diploma, BTEC national</td>
</tr>
<tr>
<td>4</td>
<td>Cert Higher Education, <strong>level 4</strong> key skills, NVQ level 4, BTEC professional award, cert, diploma, HNC</td>
</tr>
<tr>
<td>5</td>
<td>Diploma Higher Education, Diploma Further Education, Foundation degree, HND, NVQ level 4</td>
</tr>
<tr>
<td>6</td>
<td>Bachelor’s Degree, Graduate Certificate, Graduate Diploma, <strong>level 6</strong> BTEC Advanced professional award, cert, diploma</td>
</tr>
<tr>
<td>7</td>
<td>Masters Degree, Post Grad Cert, Post Grad Dip, <strong>level 7</strong> BTEC Advanced professional award, cert, diploma, NVQ level 5</td>
</tr>
<tr>
<td>8</td>
<td>Doctorate, Vocational Qualifications level 8, eg. NVQ level 5</td>
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Relation of competencies to underpinning knowledge- ensuring provision is at the correct level

<table>
<thead>
<tr>
<th>Lower Level</th>
<th>Knowledge</th>
<th>Comprehension</th>
<th>Application</th>
<th>Analysis</th>
<th>Synthesis</th>
<th>Evaluation</th>
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<tr>
<td></td>
<td>define, repeat, record, list, recall, name, relate, underline</td>
<td>translate, restate, discuss, describe, recognise, explain, express, identify, locate, report, review, tell</td>
<td>interpret, apply, employ, use, <strong>demonstrate</strong>, dramatis, practice, illustrate, operate, schedule, sketch</td>
<td>distinguish, <strong>analyse</strong>, differentiate, appraise, calculate, experiment, test, compare, contrast, criticise, diagram, inspect, debate, question, relate, solve, examine, categorise</td>
<td>compose, <strong>plan</strong>, propose, design, formulate, arrange, assemble, collect, construct, create, set up, organise, <strong>manage</strong>, prepare</td>
<td>judge, appraise, evaluate, rate, compare, revise, <strong>assess</strong>, estimate, <strong>predict</strong></td>
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Competency?
Conceptual shift to WFD approach

“One of the important conceptual leaps involved in a workforce development approach is the shift to ‘systems thinking’. This is fundamental to grasping what workforce development is about. While education and training can be part of a workforce development perspective, they essentially focus on the individual learners or workers. The deficit requiring rectification (through training) is seen to lie with that individual. No further consideration is given to the organisational context in which that person operates or the wider system at large which may ultimately determine whether specific policies or practices can be put into place.”

(Roche 2001, pg 11)
References

• Eraut, M (1997) Concepts of competence. Journal of Inter-Professional care 12, 2 127-139
• While, AE (1994) Competence versus performance: which is more important? Journal of Advanced Nursing 20(3) p525-531