Residential care home workforce development: The rhetoric and reality of meeting older residents' future care needs

Findings
Informing change

May 2010

This research explores approaches to enhancing health and social care provision for older people in residential homes through training care staff in basic clinical skills. It provides evidence on key strengths and weaknesses of different approaches, and identifies challenges for the future.

Key points

- Older people and their relatives want residential homes to offer a 'home for life'. However, as residents age, their health needs become more complex. Care home staff will need enhanced personal skills and support from healthcare professionals to meet these needs.
- An in-depth study in three residential homes confirms that health-orientated education and training of care staff can be successful, leading to increased confidence and professionalism in care staff and stronger relationships with community nurses and GPs.
- The level of basic nursing activities suitable for care staff in their new roles remains unclear. A robust accountability, liability and competency framework therefore needs to be identified at a national level to protect both care staff and older people.
- A strategic approach is also required to ensure financial support for 'new role' carers and their training. Up-skilling staff without any extra income for care homes is likely to be unsustainable. Care homes may need to price 'bed units' to incorporate enhanced care costs.
- Developing new role carers should improve choice, control and quality of life for older people in residential homes, enabling them to stay longer rather than having to move into a nursing home or hospital.
- Residential homes can provide enhanced care to the benefit of older people and the care workforce. But policy-makers will need to address the issues identified.

The research
By a team from the University of the West of England, Bristol, and the University of Warwick.

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Background

The care home sector is an important provider of services for older people no longer able to remain in their own homes. In England, over 18,000 care homes currently provide places for more than 453,000 clients. Six out of ten places are in residential homes, the remainder in nursing homes.

Older people and their relatives want residential homes to provide care for life and to maximise residents' quality of life. Staff in care homes would like to meet this desire, while policy-makers also wish to prevent unnecessary admissions to hospitals or transfers to nursing homes.

However, residential homes have traditionally catered for less dependent clients than nursing homes. Typically, they are staffed by social, as opposed to health care, personnel. As residents age, their health needs inevitably increase, leading to considerable overlap in the nursing care needs and dependency of residents in the two types of home. This situation is likely to become more widespread as people live longer.

If nursing home places do not expand sufficiently, residential homes will need to provide enhanced care to their clients. This means social care staff will have to develop basic clinical skills. As the distinction between residential and nursing home clients blurs, a continuum of care provision may be required in residential homes.

Study sites

Three types of residential home were included in the study: private, voluntary and local authority. Out of every ten residential homes in England, seven are independently owned, two are voluntary and one is local authority owned.

Site 1 – A 34-bed voluntary sector home in which new role carers were trained in basic nursing activities through an in-house health skills award, and given ad hoc support by a community nurse. This flexible skill mix innovation was initiated by a champion in the parent organisation (external to the home).

Site 2 – A 47-bed privately owned home in which the home manager identified ad hoc health-related courses for care staff to meet emerging resident needs. The objective was to provide high quality care, allowing residents to remain in the home long-term with routine community nurse support. This innovation was initiated by an internal champion, the care home manager.

Site 3 – A 40-bed local authority owned home with dedicated in-reach nursing team support provided round-the-clock. Care home staff were trained in selected nursing activities. The main aim was to prevent unnecessary hospital admissions. This innovation was initiated by an external local authority / Primary Care Trust partnership.

In sites 1 and 3, special permission was granted by national regulators for care staff to engage in nursing activities in the home. In site 2, where clinical skills training per se was not provided, no flexibility in registration was required.

A comparator nursing home was used to benchmark activities. This home had 32 permanent residents and was part of a large independent sector provider.

Overlapping care needs and staff skill-mix

> I think the level of needs of people in the homes is going up, so clearly we need the staff to go up too.
> (Local Authority Community Resource Manager)

The care needs of older people were measured in all four homes, expressed as a percentage of the care required by an 'average nursing home resident'. For the residential homes this figure ranged between 58 per cent and 65 per cent, compared to 85 per cent for the nursing home. Residents were also assessed in terms of the Funded Nurse Contribution to Care (FNCC) indicating need for nursing care. In the three residential homes, between one in four (site 1) and one in two (site 2) residents fell into High or Medium FNCC bands.

Although care staff time available per resident per week was similar in the three residential homes to that reported for the nursing home, the skill-mix differed. In the nursing home, one in four in-house staff had a nursing (RGN) qualification, but no staff had a Level 3 National Vocational Qualification (NVQ) or higher qualification. In residential homes, the percentage of care staff with a Level 3 NVQ or above ranged from 24 to 55 per cent.

Providing residents with a 'home for life'

> This is their home and they should stay put if they wish.
> (Residential Home Manager)

Evidence from interviews and focus groups confirmed the desire of care staff to meet their residents' wishes for a 'home for life'. However, this was not always easy to achieve. Care home managers all identified a shortfall in funding once a resident's needs increased.

If the added cost of staff time required could not be met by the resident or absorbed by the home, this cost was shifted to the health service through hospital admission or transfer to a nursing home. Stakeholders considered this undermined the rights of older residents, limiting quality of end-of-life care and perpetuating the differentiation between health and social care, rather than supporting integration. The philosophy of person-centred care for older people appeared to be challenged by a climate of ageism among community and hospital healthcare staff.

The reality of training the residential home workforce

> We have just got to learn to work together a bit more….trained nurses and district nurses are taking on a different role and they are trying to teach us. It is just as difficult for them as it is for us.
> (Senior Carer Level 3 NVQ)

In all three sites, care staff were successfully up-skilled in personal social care through Level 3 NVQ courses. Clinical skills development was supported by formal learning with the practice element provided by a clinical award course with in-house nurse assessors in sites 1 and 3, and through the community nurse's delegation and informal supervision in site 2.

Once trained, residential care staff were able to carry out basic clinical tasks such as monitoring and minor dressings – usually in response to the needs of a specific resident.

Findings demonstrate a need to establish more clinical relevance in Level 3 NVQ course content. A standardised quality control system would ensure more universal confidence in, and currency for, this qualification. Rolling out clinical up-skilling will require time for care staff to gain confidence in their new roles and for working relationships with community nurses and GPs to adjust.

Workforce development

> It's finding the boundaries as to what carers could do, and the accountability bit, and I want something a bit more defined before we go ahead with that, so we know that we're doing it right and we're not exposed to any kind of comebacks.
> (Residential Home Manager)

The research findings support the view that good basic health/nursing care can be delivered in a residential home with outreach to community nurses, provided there is a sound practice-driven relationship, and that care staff know when to seek nurse-led support. However, those responsible for development of the new role carer workforce should recognise that, without incentives and recognition for the delivery of improved health and social care, these roles will become difficult to sustain beyond a 'honeymoon' period.

Crucial to the development of the new carer workforce is the issue of professionalisation. This should include carer registration and recognised formal qualifications. A robust accountability and liability framework is also needed to protect both new role carers and older people. Unions could play a part in developing supportive structures for staff. There is also a need for national agreement on appropriate competencies and the nursing activities suitable to new role carers.

Elements of success

Although no single approach was identified as ideal, certain factors are important for successful and sustainable change:

- Leadership by care home managers and support from external stakeholders.
- Integrated health and social care approaches.
- Adequate staffing levels to permit acquisition of health skills without diminishing staff time for social care.
- Provision of structured community nursing and medical input.
- Shared vision and commitment amongst care home staff.
- Pay incentives for staff to undertake Level 3 NVQ and clinical skills awards.
- Access to NHS community nursing staff as teaching/learning support.
- Development of a 'learning organisation' culture in the care home.
- Financial incentives for care homes to provide specific enhanced care.
- Quality of resident and relative experience placed at the heart of change.

Next steps

> If you can earn more stacking shelves in a supermarket than you can earn providing care then I think that suggests that society doesn't value care work, and if you put that alongside the fact that we know a Western society doesn't tend to value ageing, then as far as I'm concerned culturally you've already got a challenge before you even start to look at the services that you're trying to provide.
> (National nurse advisor for the independent sector)

Residential homes can provide enhanced care, but important issues need to be addressed. The cultural divide between health and social care can be overcome through new models of care involving up-skilling of care home staff. However, covert denigration of those who care for older residents, inconsistencies in regulatory decision-making, and an emphasis on cost containment rather than consumer benefits, will all challenge innovation. As will the continued ineligibility of residential homes for FNCC, even if older people require complex or terminal care.

Increasing age and morbidity, on admission and beyond, could eventually lead to different tiers of residential care, making the current distinction between residential and nursing care homes no longer meaningful. Financial constraints limit the ability of residential homes to develop and apply end-of-life and other enhanced care skills at present. This means that the choice of 'staying put for life' in a home is removed from some older people. Residential homes will not be able to provide this choice unless there is financial support for new role carers and their training.

Health-orientated education and training of residential care staff will require more strategic working relationships between NHS community staff and care homes. Residential care homes currently differ in their access to community nursing and medical expertise.

Factors such as these will affect any attempts to improve the ability of the care workforce to meet the future challenges of caring for older people in residential care homes. At the same time, this study demonstrates that residential home staff *can* implement beneficial changes if the barriers can be overcome.

About the study

The research was carried out by Deidre Wild and Sara Nelson of the Faculty of Health and Life Sciences, University of the West of England, Bristol, with Ala Szczepura, of Warwick Medical School, University of Warwick.

Fieldwork was carried out over three years. A total of 108 interviews were carried out with residents and relatives, care staff, home managers, senior managers and local and national stakeholders. Survey questionnaires were sent to 141 staff and focus groups were conducted with care staff, residents/relatives, and home managers. Audit data was collected on resident dependency levels and home staffing and activity levels.

For more information

For more information about the project please see the full report **Residential care home workforce development: The rhetoric and reality of meeting older residents' future care needs** at www.jrf.org.uk

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