

# **A learning programme for your care home**

## **Report of evaluation**



**Dr Pat Young**  
**Dr Lesley Lockyer**  
**Tina Fear**

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## **Executive summary**

### **Introduction**

The care home programmes of learning and learning networks are an innovative educational initiative led by academic staff at the University of the West of England (UWE). The initiative provides learning to meet the needs of staff working in care homes in North Somerset, Bristol and South Gloucestershire.

The aims of the initiative are to maximise quality of life for residents in care homes and to reduce admissions to hospital. Sustainability is achieved through the development of care home learning networks which continue after the learning programme has been completed.

### **Aims of the evaluation**

- to assess the impact of the care home learning programmes and networks on service delivery in care homes;
- to explore the experiences of staff and trainers involved in the programme;
- to monitor any associated changes in hospital admissions;
- to inform further educational developments for the care home workforce.

### **Methodology**

- Analysis of hospital admission data
- Visits to learning programs
- Telephone interviews with key informants
- Knowledge café evaluation events with learning programmes and networks participants
- Examination of learning set materials and action plans

### **Findings**

#### **The need for the learning programmes and networks**

There was unanimous agreement concerning the need for the learning programmes and networks. This need results from a number of factors:

- The changing needs of residents resulting from longer life expectancy and a national policy drive to support the older person outside of a hospital setting
- The isolation of homes and traditional lack of contact with community services
- The high turnover of staff in care homes and the lack of educational provision for staff
- The need for care homes to maintain profit levels

The participants saw the purposes of the learning programmes and networks as

- Improving quality of care
- Updating knowledge
- Sharing good practice

- Networking with other homes and specialist service providers

### **The development of the learning programmes and networks**

At the time of the evaluation there were are learning programmes running in North Somerset, South Gloucestershire and Bristol, and care home learning networks in North Somerset and South Gloucestershire.

In all areas there was support for the learning programmes and networks. In North Somerset this involved collaborative working between the university, the local authority, the PCT and staff providing specialist services. Specialist staff gave presentations at the learning programme days and links were created between homes and specialist service staff.

### **The organisation of the learning programmes and networks**

The learning is free to care homes. The learning programmes last for 12 months and consist of monthly study days. The sessions are facilitated by UWE lecturers, with presentations from speakers working locally in specialist roles. Typically two members of each home attend. All staff are encouraged to participate. Each home has a folder of relevant materials and maintains action plans developed for the individual care home.

The sessions are held in care homes and follow a standard format:

1. Feedback on the dissemination of each care home's action plan from the previous topic.
2. Expert presentations on the timetabled topic (e.g. Dementia Care Management, Nutrition, Diabetes, End of Life Care), followed by discussions regarding the application of the material in service settings.
3. Preparing action learning sets and developing an individual action plan for each care home

### **The Philosophy of Learning**

The programme of learning is designed with a very particular approach and in a number of ways is quite different to conventional forms of learning. The key elements of this approach are:

- Emphasis on changing practice
- Celebration of good practice
- Inclusion of all staff
- Interactive learning

### **Feedback on the learning experience**

There was strongly felt appreciation for:

- The quality of the staff organising the learning programmes
- The quality of the speakers
- The relevance of the content
- The involvement of all the staff in the home

- The informal and supportive atmosphere
- The guidance on action planning and changing practice
- Networking opportunities with other care home staff
- Contacts made with specialist staff
- The locations and timing of the learning days
- The portfolios
- The lack of a charge for attending

There was very limited criticism:

- Low attendance at some sessions
- Level of material presented too low or too high
- Parking difficulties
- Overcrowding
- Cancelled sessions

### **Strategies for disseminating learning in the homes**

The aim of the learning programmes and networks is that the learning will not only be implemented by attendees, but shared with the wider staff group. The main obstacles to this process were thought to be time, and a reluctance of some staff to learn and to make changes. Strategies developed to pass on learning included discussion of the learning at handover meetings, staff team meetings and in one-to-one supervision sessions. Material was displayed on notice boards and the portfolio made accessible to all staff. Some managers used the learning to provide in-house training for their staff group, sometimes including the speakers encountered through the learning programmes and networks.

### **The impact of the learning programmes and networks**

#### **1. Attendance**

Despite efforts made to maximise attendance by care homes, it was felt that not all homes were taking advantage of the learning, and that attendance was low at some of the events. The main reason for this was thought to be difficulties in releasing staff. Other reasons were lack of commitment to learning by care home managers in some cases, and a belief that the training provided in-house was sufficient. It was felt that homes most in need of the learning were likely to be amongst those not attending.

#### **2. Confidence**

The learning programmes and networks have enabled all participating care home staff to feel their work is recognised and their contribution valued. There has been an increase in levels of confidence.

#### **3. Networking and sharing good practice**

The learning programmes encouraged a sense of community amongst care staff with long-term benefits in mutually supportive relationships. The learning also built relationships between care homes and staff working in specialist advisory and support roles.

#### **4. Improving the quality of care**

The action plans and feedback on the implementation of the actions plans provide numerous example of practical application of learning. Often the changes are small, facilitating implementation, but of significance in improving overall quality of care in the homes and the lives of individual residents. The impact on the quality of care was also evidenced in knowledge cafes where participants were able to provide many examples of the direct and immediate impact of learning on a range of significant aspects of practice.

#### **5. Hospital admissions**

There was a feeling amongst key informants and participants that the increased knowledge regarding medication, falls, and infection control had a preventative impact, keeping residents in the home, and avoiding admissions to hospital. The statistical evidence demonstrates there was a reduction in admissions from 2008 to 2010. It has not been possible to obtain more recent data in order to know if the identified trend continued in the following years. There is also a need for caution in attributing a direct causal link, as there are multiple factors influencing hospital admissions.

#### **The future**

Although there was support from participants for the continuation of the learning programmes, the current funding runs out at the end of this academic year. It is hoped that the networks can continue with more limited support from the university staff in contacting speakers. Concerns were however expressed regarding the sustainability of the groups without support and leadership.

A further development is proposed for sustaining learning through a system of 'champions' within the care homes to lead on best practice in one particular area of care e.g. end of life, medication, dementia care. The champions would be enabled to train and develop all staff within the care home. They would ensure best practice and act as the named person for the specific area of care for residents, and others involved in the residents' care.

#### **Conclusions**

Demographic trends increasing life expectancy, together with long term policy changes moving care of increasingly needy people from hospital to community settings, have impacted on care homes and the skills required of staff working in these homes. Despite this changing context of care, there continue to be limited opportunities for care home staff to update and improve knowledge and skills.

The learning programmes and networks evaluated in this report are uniquely tailored to meet the needs of this sector. The many strengths of the programme include:

- the passion and commitment of the organisers – creating a positive, welcoming and safe environment in which good practice is celebrated and change encouraged without blame or condemnation
- the venues – basing the learning in a home provides a non-threatening and comfortable environment for participants, easily accessible, with drinks and food available

- the timing of the sessions – maximising attendance by fitting within timetables of homes and staff with family responsibilities
- the involvement of everyone in a home – managers, nursing staff, care staff, cleaners, cooks, and other support staff learning together in an environment in which all roles are valued equally
- the relevance of the presentations – from well-informed expert speakers working in local health and social care roles, with lively and engaging presentation skills, geared to practical real improvements in care
- the interactive learning – enabling all participants from varying backgrounds and levels of expertise and experience to making an active contribution and believe in the importance of their role and their ability to make a difference
- the facilitation of sharing of ideas and experiences across homes
- the ownership of the folders and their continued use as a resource in the home
- the promotion of means of communicating learning from individual attendees to all staff in the home
- the action planning and feedback - of particular importance is the emphasis on and time and thought given to the process of action planning and feedback which ensures learning is transformed into immediate, practical and effective changes in practice of direct impact on quality of care for residents.

The model for the development of the initiative was one of partnership working, involving local authorities, PCTs and specialist services in a 'whole systems approach' to the development of the learning programmes and networks. For a number of reasons, this model was followed through most successfully in North Somerset.

Despite a range of efforts made by staff involved, there was evidence of variable attendance and a suggestion that the homes most needing the learning were least likely to attend.

It is clear that the learning provided through the programmes and networks is relevant, practical, and presented in forms which facilitate changes in practice. The evaluation found evidence of the impact of the learning programmes on staff morale and expertise, changing practices in the homes and improvements in the quality of care. Enduring links were established between individual homes, and between homes and related community services.

The statistical data show a reduction in admissions in the period 2008-10. Although would be hard to prove a direct causal relationship between hospital admissions and the training offered by the learning programme, the evidence on changing practices in the homes also suggests an impact on admissions. For example, changes in practice relating to resuscitation, infection control, use of medication, and eating and drinking were thought to be likely to reduce the need for hospital admissions.

The time in which the learning programmes have been developed has one of extreme change in the organisation of the NHS and social care. These changes include the government's agenda giving GPs power over commissioning and changes resulting from reformation of commissioning and provider organisations into social enterprises. The effect of multiple and fundamental changes in commissioning and in provision of care have led to a situation in which it is very difficult to maintain relationships needed for



the best functioning of the learning programmes. Locally many staff who have played a part in the learning programmed have changed roles.

There was support from all participants in the evaluation for the continuation of the learning programmes, should further funding be made available. It is hoped that the networks will continue, although there was some skepticism over the ability of the networks to be self-sustaining, without some element of outside leadership and continued support.

The organiser of the programme is currently exploring new avenues of training to ensure ideas on best practice are introduced in all homes and accessible all members of staff. These include a proposed initiative for 'champions' within individual homes (see recommendations below).

## **Recommendations**

1. The evidence suggests there is likely to be a continued need for learning to update and up-skill staff in care homes, to maintain networking between homes and to link homes to changing community-based services.
2. Further consideration needs to be given to issue of attendance. Whilst many efforts were made here, there may be scope for more effective publicity and greater incentives to encourage all homes to send staff. See also recommendation 7.
3. The model of learning presented here is uniquely effective in engaging staff at all levels and in facilitating implementation within the homes. It is suggested that any further educational developments should be based on this model.
4. The care home learning networks are established to continue on from the learning programmes, but are likely to need continued support and leadership from within the health service to be sustainable.
5. There will need to be continued publicity to bring new staff and homes into the existing networks.
6. The experience from North Somerset provides a model of collaborative working. Consideration needs to be given to further development of this 'whole systems' approach in other localities
7. Consideration needs to be given to extending collaborative work to include the organisations providing care homes. This may increase the sense of ownership and be effective in improving attendance.
8. A consistent approach to collecting data around hospital admissions and A&E attendance would allow particular trends and problem areas to be identified. This would facilitate policies and protocols, identifying training and education needs so that residents can be care for and treated with greater effect within their homes.
9. The development of champions within care homes, enabled to train and develop all staff within the care home to ensure best practice, and act as the named person for the specific area of care for residents and others involved in the residents' care.
10. Further developments, such as the proposal for 'champions' working within care homes, require evaluation to be built in from the early stages to enable assessment of impact.

### **Key to terms used**

Care home programmes of learning (learning programmes)	A series of twelve monthly learning events, attended by care home staff, usually running 9.45am - 3.00pm. Programmes were running in Bristol, North Somerset and South Gloucestershire at the time of the evaluation
Care home learning networks (networks)	Monthly meetings of care home staff, usually lasting two hours, which follow on from participation in a programme of learning. Networks were running in North Somerset and South Gloucestershire, but not Bristol, at the time of the evaluation.
Portfolio	File containing articles, hand-outs, action plans. Issued to each home attending programmes of learning and brought to sessions attending member of care home staff. Available in the home to all staff. Referred to by participants in evaluation events as 'folders'.

## **Introduction**

The care home programmes of learning are part of an innovative educational initiative developed and led by academic staff at the University of the West of England (UWE). The initiative provides learning to meet the needs of staff working in care homes in North Somerset, Bristol and South Gloucestershire.

The overall aims of the initiative are to maximise quality of life for residents in care homes and to reduce admissions from care homes to hospital. This is achieved by improving care home services through the delivery of a comprehensive programme of training, information and advice to care home staff. Key issues in the development of the initiative have been the importance of partnership working and creating sustainability. Sustainability is achieved through the development of care home learning networks which continue after the learning programme has been completed.

Informal feedback to the programme organisers reported increased confidence amongst care staff, with examples of care assistants becoming specialist lead workers on a particular aspect of care. The use of action learning plans in the programmes provided evidence of changes in policies and practices within homes as a result of attendance on the learning programmes. Initial data gathered routinely suggested there was a 20% drop in hospital admissions in the year following the introduction of the programmes. This evaluation sought to provide independently gathered feedback on the impact of the learning programmes and networks.

It is important to note that the initiative and the evaluation took place in a time of great change and uncertainty in the organisation of the health and social care services. Across the country, fundamental changes are taking place within commissioning and provider organisations. Locally many staff who have played a part in the learning programmed have been displaced or switched roles. This has resulted in a challenging environment in which to build and maintain the relationships needed for this work to be fully integrated with the complex web of existing services.

## **Evaluation Aims**

The aims of the evaluation are:

- to assess the impact of the care home learning programmes and networks on service delivery in care homes;
- to explore the experiences of staff and trainers involved in the programme;
- to monitor any associated changes in hospital admissions;
- to inform further educational developments for the care home workforce.

## Methodology

A combination of qualitative and quantitative methods was used to carry out a broad evaluation of the impact of the learning programmes and networks.

The following data was collected and analysed:

Quantitative measures:

An analysis of data routinely collected by NHS Trusts on

- The numbers of admissions of care home residents to hospitals, the number of bed days, and the reasons for admission between October 2008 and May 2010.
- Accident and emergency visits by care home residents between October 2008 and May 2010

Qualitative measures

- Visits to the learning programmes and the care home learning networks as part of an initial familiarisation with the learning programme
- Examination of documents such as learning set materials and action plans
- Telephone interviews with key informants, including members of the course team and managers in the Trusts and local authorities
- Knowledge café evaluation events for care home staff to explore reflections on learning, attitudes to the programmes and the networks and implementation of the learning in the workplace.

Key literature informing the development and philosophy of the programme was reviewed.

The methods used are explained in more detail below.

Hospital admission data

Hospital admission data from care homes is collected routinely by NHS Trusts and entered into Excel spreadsheets; however a number of recording methods are used.

The quantitative data supplied to the project team included the following:

- The number of emergency admissions from care homes in the BS postcode area, by month (October 2008 to May 2010) and by medical specialty
- The number of visits by residents from care homes in the BS postcode area, to accident and emergency by month (October 2008 to May 2010)
- The number of admissions from individual care homes in the BS postcode area between April 2009 and January 2010.

It was not possible to obtain data from the years 2011 and 2012.

The data were cleaned and re-coded to allow comparison and entered in to two SPSS (Statistical Package for the Social Sciences) version 19 (IBM Statistics) spreadsheets. The first contained the emergency admission data and the second the accident and

emergency data. The variables for the first data set were date (month and year), NHS Trust attended, medical specialty, and number of bed days. The second had variables date (month and year), accident and emergency department attended, and medical specialty.

The data listing individual care homes and the number of admissions from these care homes was not used in this report.

Descriptive statistics were performed and frequencies calculated to allow a comparison over time for both the SPSS data sets. An ANOVA statistic was calculated for the number of bed days by date and medical specialty for the first data set.

#### Key informant interviews

Eleven people were interviewed. Nine of the interviews were conducted over the telephone and two face-to-face. The interviews were audio-recorded and transcribed. The interviewees had a range of work roles and had been involved with the programme in differing ways. The participants included: the two tutors from the University of the West of England; three specialist speakers from the learning programme; the manager of the Rapid Response team for North Somerset; three members of North Somerset's contracts team and a commissioner; member of South Gloucestershire Local Authority.

The interviews were semi-structured. A list of questions had been prepared and checked with the programme leaders. The questions covered various aspects of the programme from the need for the programme to issues of sustainability into the future (see appendix 1). Informants were sent the questions in advance, along with an information sheet. The interviews varied in length from 10 to 30 minutes, as some informants had broader knowledge of the learning programme than others. The interviews were audio-recorded and transcribed and thematically analysed.

#### Knowledge cafe evaluation events

Knowledge Cafés have been used successfully in a number of recent research projects within the Faculty of Health and Life Sciences at University of the West of England, and has consistently received very positive feedback by participants. A knowledge café aims to enable people to work in informal but focused small groups and to think in non-conventional ways, sometimes using photographs to stimulate ideas.

Five evaluation events were held: three exploring the learning programmes and two focusing on the networks. They all were located in care homes: in Bristol, South Gloucestershire, and North Somerset. They ran for two and a quarter hours and lunch was provided. Invitations were sent by email from the programme organisers and followed up with reminders. Around 150 people were invited.

Table 1 Numbers attending knowledge cafe evaluation events

Knowledge cafe participants	
North Somerset learning programme	4
Bristol learning programme	6
South Gloucestershire learning programme	4
North Somerset learning network	7
South Gloucestershire learning network	5

A range of staff from managers to care support workers participated. They had all attended at least one session at one of the learning programmes or networks. Although the numbers attending were disappointingly low, the events produced rich in-depth data which would have been difficult to elicit from quantitative methods such as questionnaires. The low numbers also enabled the evaluation team to discuss responses with participants and avoid the need for follow-up interviews seeking clarification.

The events began with the selection of an image by participants to stimulate their thinking and provide a focus for conversation. This was followed up with more specific questions for group discussion. These questions were developed in consultation with the course team (see appendices 2 and 3). Detailed notes were taken and participants used post-its and pages from flip-charts to note their ideas. The notes and post-its were typed up and formed the basis for analysis. Appendices 4 – 8 contain the notes from each of the evaluation events.

### Data analysis

The data has been thematically analysed and the various forms of data have brought together in the following account which examines:

1. The policy context
2. The need for the care home learning programmes and learning networks
3. The development of the care home learning programmes and learning networks
4. The organisation of the care home learning programmes and learning networks
5. The philosophy of learning
6. Feedback on the experience of the learning programmes and networks
7. Strategies for disseminating learning in the homes
8. The impact of the initiative
9. The future

### Ethical approval

Ethical approval for the evaluation was sought and granted from the Health and Life Sciences research ethics committee at the University of the West of England. Since this is an evaluation of an existing service and patients are not involved, NHS ethical approval was not required. All participants were given information sheets. In the case of the Knowledge Cafe participants, consent forms were signed at the beginning of the

events. Interviewees were asked to give verbal consent to the interview and to the recording of interview. Participating homes received a book token for £20 in recognition of their contribution.

## **The policy context**

Within the literature relating to care homes, there is an acknowledgement that the sector has historically worked in isolation, separated from other statutory and independent care sectors and largely excluded from main stream care systems (Fear, 2009). Differing employment status within this independent health and social care system has resulted in a diverse and ad hoc training and education system from either privately funded or internally based from within their own organisation (Fear, 2009).

Government agendas over the last decade (DH, 2001; 2005; 2006) have demanded a shift in thinking around care of older people. The aim is to ensure that services for older people are local and accessible, provide choice and support a variety of housing from living at home to nursing home provision. The independent care system in terms of residential and nursing care is now an essential component of integral health and social provision for older people. Therefore there is a greater need for interagency education and training particularly for older people experiencing long term conditions.

Government agendas are resulting in a shift in care with less hospital beds and an increased more effective care outside hospital for older people. A *Sure Start to Later Life* report (DH, 2006) gave examples of housing choices within communities, for older people unable to remain in their own home. This extends from purchased extra care housing to public funded nursing care within nursing homes.

Partnership working has become 'a central feature of our Social Welfare Policy' (Dowling et al, 2004 p. 309). The government's programme has set out the development of a range of services to be delivered in partnership with all health and social care sectors (DH, 2001). This backdrop of current policy agendas raises opportunities for new ways of cross-sector working, to address the needs of the independent sector care homes in their continuing care provision (Fear, 2009).

As with all current developments, this evaluation takes place at a time of great change as the 2012 Health and Social Care Act drives 'the biggest shake-up in the NHS for a generation' (Brindle, 2012 p 232). The functions of the PCTs and Strategic Health Authorities will be taken over by clinical commissioning groups (CCGs). The organizational changes are accompanied by budget cuts affecting all areas of services.

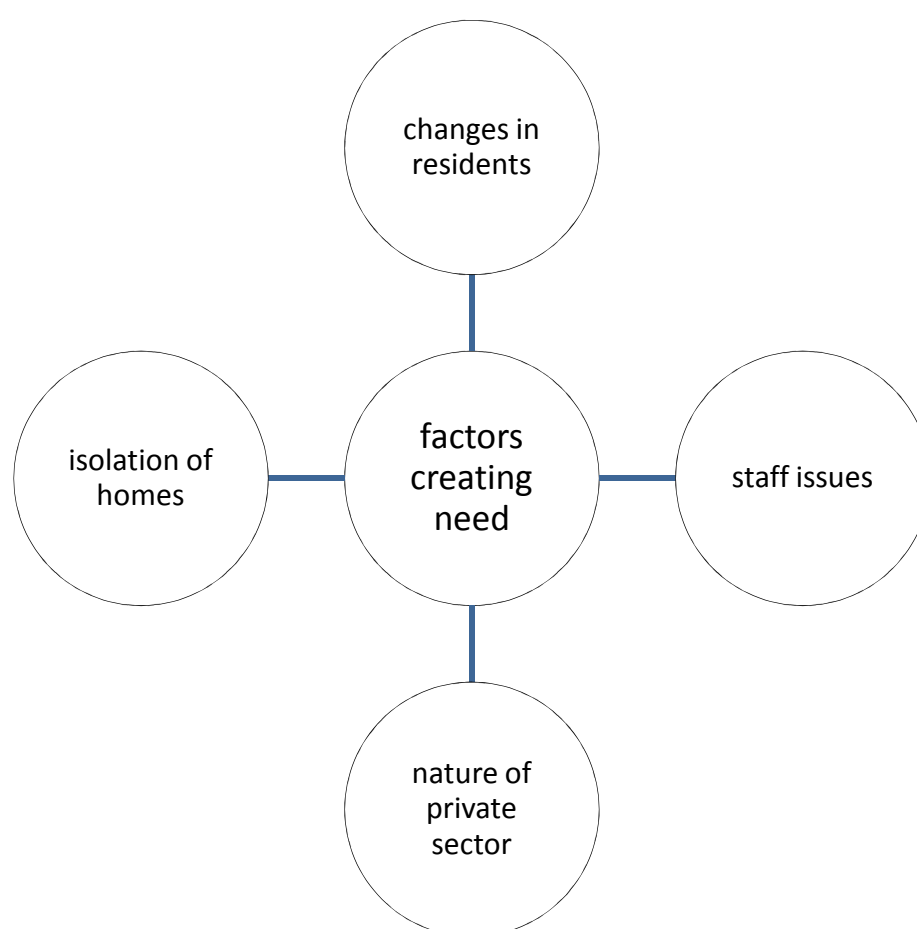


## The need for the learning programmes and networks

There are 147 care homes in North Somerset; 146 in Bristol and 94 in South Gloucestershire. All participants in the evaluation were unanimous in seeing the need for the learning programmes and networks.

As private sector organisations, care homes were considered to fall into a 'grey area', in terms of organisational support, while 'contain(ing) our most vulnerable population' (key informant interviews). Factors associated with the need for learning were linked to changing resident populations; the characteristics of the staff working in the sector; and the isolation of homes from each other and related service providers.

**Figure 1 Factors creating the need for the learning programmes and networks**



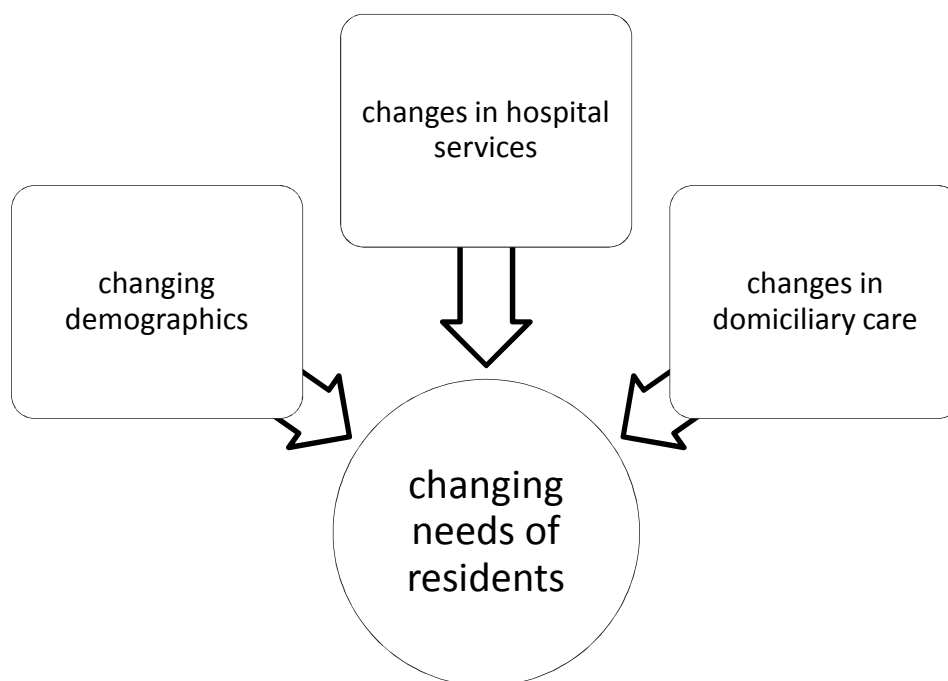
Respondents noted the changing health care needs of residents in care and nursing homes, as a consequence of government policy drivers affecting hospital and domiciliary care, and of changing demographics:

*'The people (the homes) are getting to look after have changed; ... they're more poorly than they used to be and it's about ensuring the staff have the skills to look after those people' (key informant interview)*

This was seen in terms of a domino effect in which each part of health and social care services catered for a needier group of people:

*'... when I trained (as a nurse) in the eighties, the people I looked after in an ITU are now looked after on a ward. People I used to look after on the ward, are now looked after in nursing homes, and people I probably looked after in nursing homes are now in residential homes. And those people in residential homes are probably at home, so I think the acuteness of what they're looking after has increased' (key informant interview)*

Figure 2 Changing needs of residents



Homes were believed to be characterised by high turnovers of staff, higher proportions of overseas nurses, a need to maintain profit levels, and a corresponding lack of access to education.

*'Some are privately owned companies, very small family-run units that aren't able to go to training because it's all an expense. When you've got a small home, the margins now of profit are much smaller' (key informant interview)*

Education was thought to be more commonly provided in homes which operate as part of a larger organisation. The standard of this learning was however questioned.

*'... if they are in a home as part of a big company ... they do a lot of their own training. But then I don't know how it's regulated. A lot of training now is e-learning, or in-house, but it's not regulated to a standard. It's all quite hit and miss I think' (key informant interview)*

Key informants believed that staff in care homes were often isolated. An important aspect of the learning programmes was enabling staff working at all levels to network with each other, sharing problems and good practice.

*'It was a good network where all the managers ... could get together and have chat about problems that occurred within their home ... some managers felt quite isolated and they didn't feel supported but going to the networks, they felt that they struck up friendships with other managers' (key informant interview)*

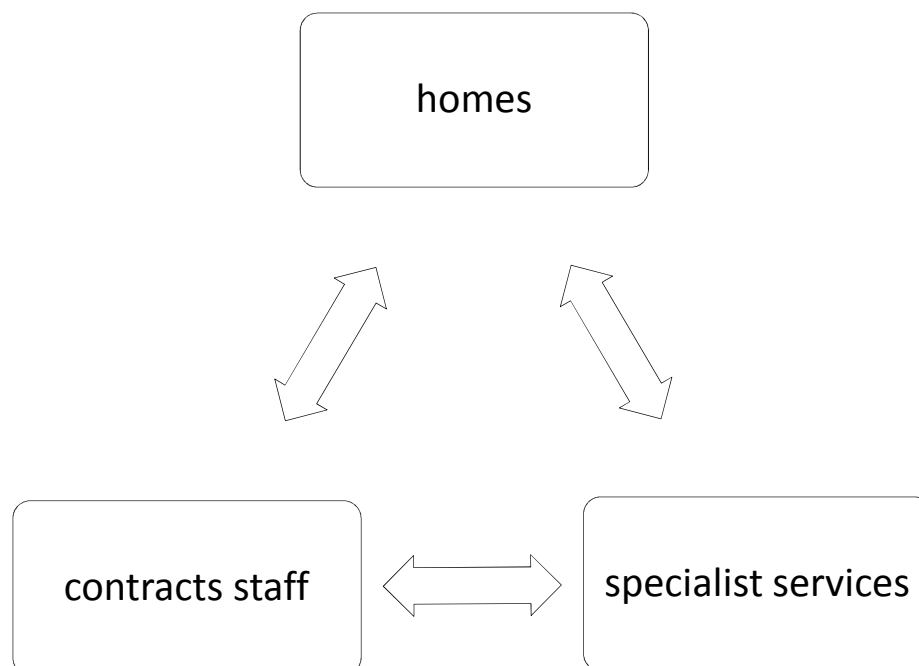
It was also thought that residents in homes tended not to receive the support of specialist services, such as dietary advice. The programmes provided a means of contact between specialist services, who providers speakers for the learning days, and homes.

*'There's not so much of a focus on visiting nursing homes. Many of the dieticians won't visit nursing homes ...that's because it's so under-funded, not because they don't want to ... as a result the nursing homes haven't received that sort of education around nutrition ...I think that there's definitely a need to do more training' (key informant interview)*

The programmes and networks also provided a means for contracts staff in North Somerset to work with homes and provide constructive support. Contract staff found it useful to monitor attendance on the programme:

*'I know if you were to run the project again, you would have full backup from the other contract compliance officers ... we thought the training was really good and ... we were able to see which Homes were taking it on.' (key informant interview)*

Figure 3 Homes and networks



The need for the programmes and networks was also seen in terms of reducing hospital admissions from homes. This is a key theme in current health policy, both locally and nationally.

Nationally, hospital admissions from care homes are often high for older people who experience multi-diagnoses of long term conditions. This has resulted in different admission avoidance schemes related to specific illnesses and diseases being tested to reverse this trend. The schemes tend to be directly related to exacerbations of a condition such as COPD (Pearce et al 2011). This trial involved collaborated working between GPs and ambulance services as a physical change in service provision as opposed to training. Ouslander (2011) developed a 'quality improvement intervention that included a set of tools and strategies designed to assist nursing home staff in early identification, assessment, communication, and documentation about changes in resident status' (p 745). It demonstrated that the specific training package appeared to reduce hospital admissions, although more research was needed to confirm this. Garcia et al (2011) identified a lack of research into management issues such as the voice of the resident with diabetes being heard (as the expert patient). This research identified the need for management education for families, residents and all health and social care providers in this setting.

The importance of reducing hospital admissions was perceived by the key informants in a number of ways. It clearly is related to the need to reduce costs of NHS care. However it was also related to residents' wishes to remain at home, and not to die in a hospital, and to an awareness of the detrimental impact of hospital admission on many older people, particularly those with dementia.

In the quotation below, a key informant expresses this duality, in terms of benefits to residents but also in reducing costs of hospital admissions:

*'if you've got somebody who has dementia and has a urinary tract infection and needs maybe antibiotics and increased fluids ... they might be okay in their own environment in the care home, because they know the people, they know the routine. ... why can't (the treatment) be given there, rather than actually they've got to get in an ambulance, get to a hospital, go onto a ward where there's no such one- to- one care? ... Also financially, the hospitals don't want people in that are going to be there for a long time because they end up as what we call 'bed blockers' (key informant interview)*

Following from this, a key aim of the programme is to enable staff in care home to extend their skills to enable residents to be cared for at home. In the words of one of the organisers:

*'So it was really about enabling staff in the care homes to have the skills to be able to care for people with exacerbations of their condition' (key informant interview)*

Again, this was set in the context of the increasing health needs of people in both residential and nursing homes:

*'there are lots of people with chronic diseases, so you have exacerbations of COPD, asthma ... so the nurses have suddenly realised that they haven't got the skills for this as we raise the standards and the skills needed to care for their clients really ... So we have actually changed the*

*philosophy of how nursing homes function ... the majority are functioning like mini- hospitals'*  
(key informant interview)

Participants in the knowledge cafe evaluation events were asked to express their perceptions of the purposes of the care home learning programmes. A commonly voiced theme was the value of the opportunity to gain up to date knowledge on good practice, to improve standards of care for residents. The learning enabled staff to understand why they were being asked to work in a particular way, and to gain a better understanding of care home policies. A valued purpose was seen in the opportunity to network with staff from other care homes, to share ideas and examples of good practice. The learning programmes also served to improve the reputation of the home, to support contract compliance, provide material for records of training for home and for registered nurses required to undertake CPD.

What are the purposes of the learning programme?

- *'To improve quality of care'*
- *'To focus on good practice'*
- *'Up to date knowledge'*
- *'The purpose of the learning programme I think is to interact with others and learn other's ideas and possible improvements'*
- *'To give more information into important subjects within care'*
- *'To give the junior staff the opportunity to learn and realise they are very much an important part of the team'*
- *'For senior staff to realise changes do occur and we must be on top of this'*
- *'Care staff become more aware of the reasons why procedures and policies are in place'*

(written responses from learning programmes knowledge café participants)

Participants in the knowledge cafe events feeding back on the care home learning networks were also asked their views on the purpose of the networks. There was a similar emphasis on sharing and networking, gaining contacts with specialist resources as well as learning new information and skills. Audit and inspection purposes also featured.

What are the purposes of the learning network?

- *'An audit tool to show in inspections'*
- *'Makes you realise that you are not alone / isolated. Establish relationships'*
- *'Instead of being in competition, feel confident to ring people and ask for information'*
- *'Share information and learn more about things we need help with'*
- *'To develop knowledge, get people talking'*

- *'Encourage relationships between outside professionals and care homes*
- *'Learning new things*
- *'Gaining knowledge, networking, getting to know people and gaining contacts*

(written responses from learning networks knowledge café participants)

## **The development of the learning programmes and networks**

The current care home learning programmes were preceded by groups known as care home network groups. These were established in North Somerset in 2003 by the UWE lecturer who leads the current programmes. Subsequent funding from the local Primary Care Trust enabled two 12 month programmes of learning to be run to support care homes in North Somerset.

Further development came after the Strategic Health Authority for the region learned of the success of the programmes. It was felt that all the Trusts should make similar provision, with the additional aim of reducing hospital admissions. As a result, Service Improvement Fund (SIF) monies from the three PCTs led to two further programmes in North Somerset, two in South Gloucestershire and two in Bristol. The Bristol programmes were delayed in starting, but began in September 2011 and followed an accelerated programme of twice monthly meetings. All will finish in July 2012, making a total of eight.

After the programmes are completed, groups join together to form networks and continue the learning sets, meeting monthly on Wednesdays. There are currently networks meeting in Bristol, Clevedon, Weston Super Mare and South Gloucestershire. There is no charge to homes for attendance at either the learning programmes or the networks.

In all three areas, there was support for the learning programmes from the local authorities and PCTs. In North Somerset, there was been considerable involvement of the local authority and the PCT in the development and running of the programme. This involvement began in the initial stages when the PCT brought community services key nurses and other specialist staff, already tasked with providing training in nursing and residential homes, together with other interested parties:

*'I was asked to set up a group of interested parties ... that would include ... the UWE trainer ... We had someone from Rapid Response, the out of hours service, district nursing, specialist nurses as well. As a group we met about once every six weeks or two months and went through all the work that everybody had been doing and we also identified which homes we felt were struggling and needed more support.'* (key informant interview)

The ongoing commitment from the PCT was linked to the aim to avoid admissions to hospital and homes with high admission rates were particularly targeted.

*'(we) looked at which homes had the highest admissions to hospital. We'd go out and do a visit with them and talk about their learning needs, go through some of the cases of why they admitted the patients and then talk to them about the learning programme; were they involved; did they attend, you know, and what they were getting out of it so we sort of did a constant evaluation and promotion all the way through really. ... from the PCT point of view our overall aim was to avoid admissions to acute care'* (key informant interview)

A team of four contract compliance officers (CCOs) worked in North Somerset to assure the quality of the services being provided by the care homes against their contracts with the local authority. This work included visits to homes:

*'... they would be able to spread the word and really encourage people to take part ... they really worked hard at promoting it'. (key informant interview)*

For the course organisers, this involvement provided links to appropriate speakers and integrated the learning programmes and network within the wider context of services in North Somerset:

*'... the PCT has worked with us ... We have been able to work with all their organisations so Rapid Response, community matrons. Also the PCT staff that have got specialties like tissue viability or end of life. So they have been very willing to help, and have had a vision really about how this programme could reduce hospital admissions. ... they have taken that very seriously and I have regular meetings with the PCT staff' (key informant interview)*

The benefits of enlisting community staff as speakers were seen to work in both directions, also enabling the specialist staff to economically have contact with a number of homes:

*'... in North Somerset the community staff have got on board, the Infection Control Specialist Nurse; Diabetic Specialist Nurse; End of Life, they've come in, voluntarily and quite see it as a part of their role ... Because they say, in one visit they can probably see ten, twelve, fifteen care Homes....it's easier to do that than do fifteen visits to individual homes' (key informant interview)*

The involvement of North Somerset contracts staff included attending some of the learning programme sessions and monitoring attendance.

*'... when we started this, it was the star rating system and there were a lot of care homes that were rated as '1' as poor and ... because it was free training, we felt it would be a really good idea to try and promote the learning project, especially for those care homes ... we used to go to several of the groups and note what care homes were there ... (key informant interview)*

For the organisers, this was a positive step, designed to support homes.

*'they would actually see which homes were coming regularly, if they weren't they would ring up and say, "oh come on you know, send somebody because you know you've got this safeguarding issue". Or "this would be really good for you because you know if your resident such and such". And they also helped us to recruit homes that needed to come, that were scoring poorly around quality from the CQC and things so they have been very proactive and if we say "oh such and such a home I've asked but they haven't come", they will ring up and "say why haven't you been?" (key informant interview)*

However, as is shown below, resentment was expressed by one of the knowledge cafe participants, over the presence of the North Somerset staff at some of the early sessions and the linking of the learning to issues of contracts and funding. The issue of which homes attend the programmes is explored more fully in the section assessing the impact of the learning.



## **The organisation of the learning programmes and networks**

The learning programmes last for 12 months and consist of monthly study days, running on Thursdays between 9.45 and 3.00pm. The topics are chosen by the care homes managers at the beginning of the year. The sessions are facilitated by UWE lecturers, typically with speakers from the local PCT. Action learning sets are utilised. Each home has a portfolio of relevant materials and maintains action plans developed for the individual care home, as a result of learning in the sessions. As has been stated, homes are not charged for the materials or for staff to attend.

Typically, around 25 staff attend each session (attendance is discussed later in this report). Two members of staff from each home are invited, although occasionally more attend. Ideally, there should be one senior staff member and one more junior. It is expected that different people attend each month, to ensure sustainability in a sector where there is a high turnover of staff.

Lists of sessions are pinned up in the home and staff sign up to attend. Homes are encouraged to send the most appropriate members of staff to the events. For example, the first meeting will be attended by a manager. The meeting will focus on a 'SWOT' analysis, exploring what the home is good at and what needs further development. Later sessions might be on aspects such as nutrition, in which case the cook should attend, or infection control, when the cleaning staff would be encouraged to attend. Some homes have subsequently designated individual staff as lead specialists in particular aspects in which they have developed an interest.

The sessions are held in care homes and follow a standard format:

1. Feedback on the dissemination of each care home's action plan from the previous topic. This requires person attending to have talked to last week's attendee. They are expected to bring the folder and to be able to feed back on what has been implemented from the previous session's learning.
2. Expert presentations on the timetabled topic (e.g. Dementia Care Management, Nutrition, Diabetes, End of Life Care), followed by discussions regarding the application of the material in service settings.
3. Preparing action learning sets and developing an individual action plan for each care home so that participants are able to formulate their feedback from the session and determine how best to present it in their workplace.
4. In addition, each care home involved in the project is contacted by telephone/email/visit between study days to offer support in putting their action plan into place. Each care home has been provided with a portfolio to include course literature, action plans for dissemination to all staff within their workplace and a reflective log on their learning.

Figure 4 Implementation of learning



The care home learning networks are developed after completion of each learning programme. Groups in a local area join together to form a network and continue as learning sets, meeting monthly on Wednesdays. Network meetings are less formal, although participants still bring their folders, and action planning continues to be used. The sessions are shorter, just three hours. The topics are requested by the participants, but currently speakers continue to be arranged by the UWE staff. It is hoped that the groups will take on their own facilitation in the future.

Considerable effort is made by the organisers to recruit homes to the learning programmes and to support attendance at the learning programmes and the networks. Each month, a flyer is sent out to homes, two weeks before the session. An email is sent to the manager a week before the session, and then they are phoned by one of the organisers in the week of the session just to remind them. Despite this attendance is variable and further emails are sent to explore reasons for non-attendance. This is explored further in the later section on the impact of the learning programmes and networks.

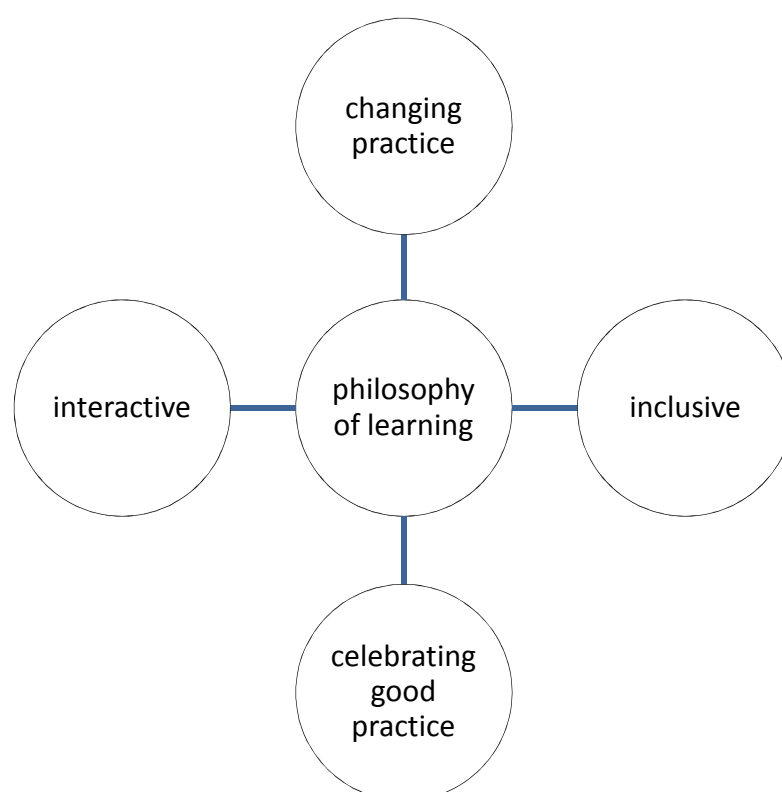
## The Philosophy of learning

Although there have been many initiatives set up to address education and learning in the care homes setting, there is little evidence in the literature of a coordinated approach to develop a learning climate, develop partnerships with other health and social care systems and integrate theory to practice. The programme of learning is designed with a very particular approach and in a number of ways is quite different to conventional forms of learning.

The primary aim is practical, rather than academic. The emphasis is on changing practice in care homes:

*'We are trying to give the practical application with theory, to enhance care, to change practice'*  
(key informant interview)

Figure 5 The philosophy of learning



As well as being a stimulus for change, the programme aims to celebrate success - in a sector which is criticised more than praised, and in which staff work hard in challenging circumstances, and for little reward or status.

*'it's not always about criticism ... they say 'oh we are doing that already', and I say 'well that's wonderful, go back and tell your staff please, put a notice up saying that we have just had an update and you are doing the best practice. You should be congratulating them'. So it isn't*

*always about changing practice. It's about changing their approach to their staff and celebrating'*  
(key informant interview)

An important difference between the learning programmes and networks and conventional education is that the learning is aimed at the whole care home and not just the individual people who attend a particular session. The portfolio plays a key role here:

*'the portfolio is for the whole care home. So that comes with everybody who comes every month ... developed and getting bigger with all the articles and the knowledge and their feedback and their actions plans. So it's really difficult to say who owns that'* (key informant interview)

In the early days of the programme, a certificate of attendance was awarded at an event. This created a dilemma around who should receive the certificate. In the end, the idea of the certificate was dropped. The whole home approach extends beyond care staff. As a key informant comments:

*'I particularly liked that it wasn't just aimed at managers or lead nurses, the cooks also were there. The handyman was also expected to be there ... and it's that winning cultural hearts and minds ... Because everybody is important, it's the same with any team ... there's nobody more important than somebody else because if somebody isn't doing their job, the whole team winds down'* (key informant interview)

The learning is highly interactive and designed to involve everyone at every stage in their learning. One of the course organisers explains the way in which participants are involved in identifying their own learning needs:

*'... it's about them being interactive. It's about us being interactive. It's about us saying to them 'okay, so we've got diabetes today; what do you want to know about diabetes?' ... And ensuring we give them what they want ... and meeting all their different needs'* (key informant interview)

Participants come to the learning programmes and networks with very differing backgrounds:

*'We will have somebody who's seventeen, and out of school, and done nothing, and we'll have somebody who's done it for thirty years, and we'll have somebody who's trained. And we'll have the cook. So it's about meeting all those needs'* (key informant interview)

The philosophy of interactive learning informs all aspects of the work of the UWE tutors with the participants. Visiting speakers are also encouraged to involve participants in learning. An example can be found in a session on nutrition which included participants feeding each other, tasting fortified milk, and thinking up ways to increase the nutritional value of foods and drinks served in the homes. This session was memorable enough to be discussed in the evaluation events and managers described repeating the training with full staff teams.

As is shown in later sections of this report, on the feedback from participants and the impact of the programme on quality of care, the use of the portfolio as a shared resource, and the inclusion of all the staff in a home, are particularly valued aspects of the learning.

The action planning is another key element. Presentation of new information is deliberately limited to short morning sessions, to allow the afternoons to be spent on transforming these ideas into achievable plans to change and improve practice. The organisers take considerable time and effort to work with the participants to ensure the learning is turned into manageable, achievable objectives which can be passed on to managers and other staff in the home. Action plans are recorded and stored in the portfolio.

## Feedback on the learning programmes and networks

There was much praise from the key informants and the knowledge café participants for all aspects of the learning programmes. The events were described as 'well run' (knowledge café participant) and the emails reminding homes of learning events appreciated. Participants at the knowledge cafes felt the locations worked well: close enough to be easily accessible, comfortable and informal, without conjuring memories of school learning. Visiting another care home was seen by one of the key informants as a source of potential learning in itself:

*'It's in a Care Home and I think that was an excellent thing as well, because most Managers don't go to other Care Homes, and I think that is a really good idea to go and look at other Care Homes to see what they've got' (key informant interview)*

The timing fitted well with shifts, and busy times in the homes, and enabled people with childcare responsibilities to participate. The breaks between sessions were welcomed and the 'short sessions which make it easier to remember what we have learned' (knowledge café participant). The lack of charge was also an ingredient for success.

It was felt that the organisers had the ability to enable everyone to relax and feel confident about participating.

*'The UWE staff make people feel relaxed and comfortable about participating.'*

The degree of interactivity was enjoyed and valuable to learning.

*'I went to one, and it certainly seemed to me that (the organiser) put an awful lot of thought into how to make it absolutely totally appropriate for the kind of people. It was very interactive, and she managed to get everybody talking' (key informant interview)*

The work of the organisers in supporting the implementation of learning into manageable changes in practice was also recognized.

*(The UWE tutors) guide people to see other ways of making changes and make change manageable' (knowledge café participant)*

There was praise for the quality of the guest presenters and, in particular, their specialised knowledge gained from current and credible practical involvement. The opportunities to learn from colleagues working in different homes, and in different roles, were also valued. Participants appreciated the direct practical relevance of all the learning to their work, which enabled immediate implementation into the care setting. There was also benefit in

*'learning what we do already know' (knowledge café participant)*

The knowledge and confidence gained enabled staff to make positive suggestions for change. For one of the managers, an ingredient of the success was that:

*'Staff volunteer to attend topics they are interested in. Some come on their days off. It is ideal if they choose to come, they are keen and they want to learn' (knowledge café participant)*

The level was felt to be appropriate for most staff in most of the sessions.

*'Level excellent for majority, support workers didn't feel it was over their heads (knowledge café participant)*

The role of the action planning was acknowledged,

*'the staff have to sit and listen, they have to come back with something' (knowledge café participant )*

The portfolios (described here as folders) played a key role in the continuity of learning:

*'people have to read them in order to be ready to answer questions about last time. It is good as the folders get used. There is good literature in the folders.'* (key informant interview)

Another participant described the folder (portfolio) as a 'bible', and commented that people did not forget to take it along when they attended, generally took it seriously, and by reading the portfolio, could feel involved even if they had not attended before and be able and ready to participate.

The recapitulation of the previous session was useful in consolidating learning, and to bring people who had not attended that session up to date.

What the things that make the learning programme a success?

- *'You get to meet new people with different experiences that you can learn from as well as getting important information from specialist speakers'*
- *'Comfortable room and comfortable chairs, not having tables and chairs which would make it feel like school'*
- *'Consistency in venue and familiar faces enabling you to open up to talk more easily'*
- *'Interesting and engaging speakers'*
- *'Topics relevant to the work'*
- *'A lot of information has been able to be implemented into work settings'*
- *'Encouraging all staff members to attend, something for everyone'*

(written responses from learning programmes knowledge café participants)

There was similar praise for the care home learning networks which continue the learning process after completion of a learning programme.

What the things that make the learning network a success?

- *'Communication, tutoring in a variety of subjects asked for by the network team'*
- *'Meetings are about topics that are chosen by us as areas we need help with'*
- *'The topics are chosen by us and it's what we feel is important'*
- *'Good speakers who know their stuff. We find out the roles exist'*
- *'Location and timing is practical for busy managers (short time periods 9.45-12.00; local means can be called back in an emergency)'*
- *'Networking has proved to be valuable in improving the service'*
- *'Listening and learning about how other care homes work'*

(written responses from learning networks knowledge café participants)

Participants were also asked to identify 'the things that (are) not so good about the learning programme'. Here the lists were much shorter. The most commonly expressed theme was the low numbers attending some of the events. On the other hand however, there was a complaint that the venue, although appreciated for its comfort, had been crowded for some sessions. For some of the staff the level was occasionally more appropriate to trained staff. For others it was felt that the learning was pitched at a level which did not stretch trained staff. At some of the events, parking was tight. It was also thought that there could be a 'Chinese whispers' quality to the information passed on, when only one member attended. At one of the evaluation events, there was strongly felt criticism from one participant of the attendance of North Somerset contract compliance staff. It was suggested that the staff made remarks that were

*'not positive and made me feel uncomfortable about attending' (knowledge café participant)*

These remarks were perceived as threats that homes would not be funded if staff did not attend:

*'The programme wasn't sold on the basis of getting funded, or being inspected, it was training. This was not constructive or positive. They were on the phone in the sessions, phoning homes who hadn't attended. It was rude to the speakers. We were relieved when they left part-way through the session' (knowledge café participant)*

Whilst this manager was committed to sending staff it was felt that there were times when:

*'in the real world residents come first' (knowledge café participant)*

Advertising was described as 'low key' and some managers reported they had heard about the learning programmes only through other people.



What are the things that are not so good about the learning programmes?

- *'Sometimes it is hard to follow things if the speaker is talking at a level above you, feel reluctant to ask questions if the jargon is difficult'*
- *'The session was quite difficult today for someone without nursing training'*
- *'The parking here is quite difficult'*
- *'When notes are being passed on to the next person, it's like Chinese whispers, so could lead to false information'*
- *'Not enough people come. It is a big commitment but homes need to commit to it'*

(written responses from learning programmes knowledge café participants)

The feedback from the care home learning networks was a little more critical. As well as the point mentioned above regarding attendance from a larger number of homes, there was some negative feedback regarding the organisation of the learning sessions. It was intended, by the organisers, that this would be a point at which the UWE tutors would take a step back, in the interests of creating sustainable mechanisms for ongoing learning (see also the later section of this report, on the future for care home learning). It was hoped that, in doing so, new leaders would emerge to take on the role of organising events. Perhaps as a result of this attempt at transition, there was more criticism of organisational factors.

What are the things that are not so good about the networks?

- *'Considering how many homes are in Clevedon, need more to participate'*
- *'I keep falling off the email lists'*
- *'Last minute changes to meetings or topics'*
- *'Speakers not turning up (when ill, but we could have met anyway and had discussion)'*
- *'Cancellations – when (the home used as a venue) was closed due to sickness (but we could have moved to an alternative site)'*
- *'Speakers are sometimes repeated'*
- *'Not as organised as it could be'*

(written responses from learning networks knowledge café participants)

The final question in this section of the evaluation events asked 'What could be changed to improve the learning programmes?' Again there was a more limited list of ways the programme could be improved. The improvements suggested tended to follow up on the previous question. It was felt that speakers billed for a particular date should attend. One participant working in domiciliary care would welcome learning geared to that

sector, another, working in mental health asked for material relating to mental health issues such as mental capacity legislation, safeguarding, deprivation of liberty. One suggested sessions be repeated to enable more staff to access the learning; another said senior staff should be required to attend with another member of staff. Although handouts are often given, and material presented on Powerpoint is always available, it was suggested that

*'It can sometimes be difficult to remember everything covered. Maybe we could have some handouts with good point to take back to the care homes with you to show others' (knowledge café participant)*

Finally, it was felt the sessions could be improved if speakers learned more about the people attending, and geared the level of the information given to the people present.

What could be changed to improve the learning programme?

- *'More homes to attend regularly'*
- *'May be good to have some handouts or some web addresses for staff to make a folder for themselves, even a smaller folder for each student'*
- *'Not so much changed, but a specific requirement that one or two senior people come with another member'*
- *'The action plans only have the points that the last person thinks were important but there may have been others, print-outs could be given'*
- *'Notes from training to be given to the home as everyone picks up different aspects of things'*

(written responses from learning programmes knowledge café participants)

What could be changed to improve the networks?

- *'Need someone constantly at the helm – organising, since less UWE input there have been more cancellations. Managers need 'outside' help (have other priorities)'*
- *'Need more homes to participate (some came once or twice, then not again)'*
- *'More homes to take part'*
- *'Some homes are still not taking part; without a lead it is difficult to organise meetings'*
- *'More information on what the speaker will be covering in detail'*

(written responses from learning programmes knowledge café participants)

## Strategies for disseminating learning in the homes

In most cases only one or two members of staff will attend a particular learning session. The aim is however that the learning will be not only implemented by attendees, but shared with the wider staff group. In the knowledge cafés, the main obstacles to this process were thought to be time and a reluctance of some staff to learn and to make changes.

The knowledge cafes explored the means which homes had developed to share learning. A number of strategies were used to pass on learning. These included discussion of the learning at handover meetings, staff team meetings and in one-to-one supervision sessions. Material was displayed on notice boards and the folder made accessible to all staff.

*'Shift handovers – talked about in handover, even when people didn't themselves attend'*  
(knowledge café participant)

*'The folder is available, everyone knows where it lives'* (knowledge café participant)

*'We have a notice-board in the staff room on which we have all sorts of information from this programme'* (knowledge café participant)

Some managers used the learning to provide in-house training for their staff group, sometimes bringing in the speakers they met through the learning programmes and networks into the home to work with the staff.

*'After the session on feeding, where we fed each other with yoghurt, I made my staff do this. I had them do it badly and properly and experience what it is like'* (knowledge café participant)  
*'I got people to suck on a sweet and work out what they needed to do to swallow'* (knowledge café participant)

*'The CQC came to the home and asked the staff questions. I had just passed on my learning from the risky swallow session: she was very impressed at the way they all could answer her questions'*  
(knowledge café participant)

## **The impact of the learning programmes and networks**

### **1. Attendance**

Invitations to each learning programme were extended to fifteen homes located in the local area. Two people per home were expected to attend. The learning programmes are hosted by a home in the locality and numbers are limited by room sizes.

The organisers reported that attendance tended to vary by topics, with some topics being perceived by homes to be more relevant to their needs. Attendance was between 10 and 35 in Bristol and South Gloucestershire, with 20-30 people generally attending in Weston Super Mare. The organisers believed that some homes which function as a part of a large organisation did not come as training is provided in-house. There was also felt to be some cynicism about free training: a feeling that 'there must be a catch' (key informant interview).

As seen above, participants at the evaluation events were disappointed at the low numbers of people attending some of the sessions and wanted to see more homes more consistently attending. This issue also arose in key informant interviews:

*'We (the contracts staff) were all really quite disappointed with the amount of care homes that took on the training. It was quite poor' (key informant interview)*

As has been described, contracts staff working in North Somerset attended some of the sessions

*'... I went mainly to the groups held in Clevedon and I would say there was a maximum of about seven, six or seven care homes that actually came each month. ...' (key informant interview)*

A range of different explanations were offered. None of them were in terms of the course itself. Staffing in the homes were most commonly mentioned cause of difficulties:

*'...I think it was due to them not having enough staff to cover the home while they sent staff on the course' (key informant interview)*

One of the informants referred to a home which had attended one session only. Here the reason was thought to be a belief that the learning programme duplicated existing training:

*'...I think it's beneficial for all homes and my goal was to get every single home in North Somerset, attending if I could. But this particular home wasn't rated as a 'poor' home but they felt that the training they were having was covering what they needed and it was issues around releasing staff' (key informant interview)*

As has been mentioned above, some of the large organisations running homes have training departments and provide in-house training. However it was felt that the learning provided by the learning programmes was unlikely to be replicated in breadth, depth and quality.

*'The learning programme' covered an awful lot of subjects that you may not necessarily have in your in-house training. Most of the care homes will only need to cover the mandatory' (key informant interview)*

Amongst key informants, there was a widespread sense that, while the programme was of value to all homes, there were some in more need of it than others. It was commonly felt that the homes least likely to attend were those in most need.

*'The ones who came were no surprise ... the ones who turn up for everything ... the better quality homes' (key informant interview)*

*'more often than not it was those that would have been, three stars, you know the good homes that took on board the training unfortunately' (key informant interview)*

Reluctance to free staff to attend was a key issue, although it had been stressed that any member of staff could attend:

*'one of the reasons was ...not being able to release staff ... We used to emphasise the fact that anybody could go, according to the subject matter. If it was about nutrition, then we would have been encouraging the chef, or somebody that was involved in cooking in the home to come along, but more often than not it would be the senior members of staff or the manager' (key informant interview)*

But it was also felt that some managers did not understand the value of training and lacked commitment to attending. As has been noted, in North Somerset a concerted effort was made to promote the course at every opportunity and considerable time and effort is also put in by the organisers in trying to ensure and raise attendance. One of the organisers reported on emailing homes following poorly attended sessions. Homes respond reaffirming their commitment to the course. The reason is usually staff shortages due to sickness.

*'the last poor attendance we had, I e-mailed all the homes to say, "you know yesterday you said you were coming and you haven't turned up today, I've got to see whether it's actually viable to carry this on" and it's interesting that e-mails have come "yes yes we do want to carry on".' (key informant interview)*

Again, the reason is most commonly due to staff shortages

*... if somebody is allocated to come, and then somebody else goes off sick, well they're just pulled in to cover ... they don't have that pool of staff to call upon. Somebody might be allocated and then go on holiday, nobody else is allocated to come. (key informant interview)*

Here again, however, there was felt to be an underlying issue of the value attached to the education of care home staff.

*'It's about the home giving the worth actually, a value of coming and some homes are very good at doing that and other homes aren't ...If you've got a manager ... known to be very proactive, very much into learning ... to develop their staff, then they are very proactive in coming. And then you've got others that actually you'll get the same carer that comes every time because*

*she's interested and she says 'well no-one else wants to come you know. And I come because I want to come and my manager's not really bothered'.* (key informant interview)

## 2. Confidence

A key aim of the care home learning programmes is enable care home staff to feel their work is recognised and their contribution valued. One of the organisers comments:

*'some of (the care staff) ... feel they're not worthy of coming "I'm only the carer" I think "actually, you're not only the carer, you're very very important". And I think it's about us saying that to them and, quite often, they do go away ... with a bit of a skip in their step because actually we have valued them and valued what they've said. Some homes send people on it that they know are not proactive ... it might be because they don't have confidence.'* (key informant interview)

One of the key informants from North Somerset reports:

*'(The Contract Compliance Officers) could see what a difference it was making to people. They could see where managers were gaining confidence and where staff teams were really engaging.'* (key informant interview)

## 3. Networking and sharing good practice

Staff working in care homes can be isolated from colleagues in other homes and from related community-based services.

*'it's more than just them sitting there and learning ... they chat to each other and actually they all have the same sort of issues, it's about them feeling not alone. ... they don't get it anywhere else ... they do have managers' meetings, but I think at the Carers level, they don't have that opportunity'* (key informant interview)

The learning programmes and networks provide opportunities for sharing problems and solutions. Supportive relationships are built which form the basis of a community of practice extending beyond the learning days.

*'people go to a course not knowing anybody, and come away feeling they can lift a phone and talk to somebody'* (key informant interview)

*'one of the legacies is that there was a bit of buddy system developing amongst homes ... that's always good news. ... For example, they have to have emergency plans. If you actually know somebody down the road you're likely to have a tighter emergency plan between two homes than you are on your own ...'* (key informant interview)

Another way in which the learning programmes and networks have impacted on care is by providing a link between homes and the services available to support them. This is welcomed by both homes and specialist staff.

*'We are contacting (the specialist infection control nurse) who is coming to the home and bringing her Glogerm hand washing equipment for all staff to use'* (action plan feedback)

*'I found from doing the training sessions, it gives them a link then to have somebody to go to for advice and support ... collaborative working really isn't it?' (key informant interview)*

And

*... 'I get a lot of personal satisfaction when people will contact me in the weeks following the sessions ... they feel that they've got a contact and they've got a sort of a support mechanism and somebody to go for help and guidance. ... if we've made a difference for one or two patients that means a lot to me' (key informant interview)*

#### 4. Improving the quality of care

As has been explored earlier in this report, the implementation of new learning to change policy and practice is a key element in the design of this initiative. This is something which is commonly very difficult to evaluate. However, in this work, the built-in action planning which follows the learning, with feed-back the following month, enables assessment of the impact of the learning, as an integral part of the learning itself.

The action plans created by the participants with the support of the tutors, and the feedback on the action plans the following month, are all documented and retained by the course organisers. These documents provide a wealth of evidence of the impact of the learning on the quality of care provided within the homes. Some examples of this impact are explored here. (See appendices 9-11 for further examples of action plans from each of the Bristol, South Gloucestershire and North Somerset groups.)

The examples below are from feedback following a session on infection control. They illustrate how the learning has immediate and beneficial impact in changing practices in the homes

*'We used to have one linen skip at our home and we have three storeys, so used to carry linen from floor to floor. Now we have one linen skip per floor, so are no longer carrying linen around, unless it is in a linen bag' (action plan feedback)*

*'We had tabards to wear at meal times, but did not use them. Now we wear them.' (action plan feedback)*

*'We have standardised all pad bins and they all now have foot pedals rather than hand opening' (action plan feedback)*

*'We have added more hand washing signs above all sinks in all residents' rooms and staff toilet' (action plan feedback)*

The following examples are from a session on nutrition:

*'Snacks are important and we have the option of not just biscuits. We offer alternatives such as fruit and high calorie snacks' (action plan feedback)*

*'Drinks are fortified for some residents and we have been weighing them weekly. They have increased weight, or remained the same, they have not lost weight' (action plan feedback)*

*'Food presentation of pureed diet has changed. Instead of all the ingredients being put in one bowl, each component is plated, so residents are more aware what they are eating, for example carrots are pureed orange, peas are pureed green' (action plan feedback)*

*'We are offering visibly different choices, which helps the resident understand what is on offer, rather than verbally telling them' (action plan feedback)*

These provide examples of practical immediate application of learning. The changes are small, therefore easily implemented, but of significance in improving overall quality of care in the homes.

The impact on quality of care was also evidenced in knowledge cafes where participants were able to provide many examples of the direct and immediate impact of learning on varying aspects of practice.

*'We now have two emergency trolleys, one on each floor, so all the equipment to deal with emergencies is on one place and can easily be moved around. We check the trolleys once a week' residents' (knowledge café participant)*

*'Encouraged staff to use correct infection control methods eg hand washing, use protective equipment eg gloves properly residents' (knowledge café participant)*

*'Disposable resuscitation masks. After the study day on emergency situations, we purchased two more pocket masks for cardiac arrest situations, to enable staff to give mouth-to-mouth resuscitation. It is on our agenda to review procedures and staff training and re-familiarise staff residents' (knowledge café participant)*

In some cases, examples illustrated the impact of the learning for a particular resident:

*'With a specific resident, whose condition was not improving, listening to what we learned, we decided it was time to get the GP in' (knowledge café participant)*

The contact with specialist services led to care home staff identifying residents who would benefit from community services available.

*'A gentleman resident in the home was tube fed. After the session with the SaLT team, we brought them in to the home and they said the man could swallow. We gradually built up his eating and now he eats one meal a day. It is a huge change in his life. His mouth is cleaner and his breath fresher. He can't speak, after a stroke, but he could say he was thirsty, and now we give him drinks' (knowledge café participant)*

*'A resident had a cough and was on anti-biotics. In the feeding session we heard a cough could be caused by crumbs of food. I never would have thought of that, none of us did. We brought the nurse into the home for a visit and now the cough has gone' (knowledge café participant)*



## 5. Hospital admissions

Data were obtained detailing hospital admission and accident (A&E) and emergency attendances for care homes with BS postcodes from October 2008 to May 2010. There were 2,639 documented hospital admissions and attendances and 2,454 A&E attendances during that period. The hospital admissions contained 1,624 admissions that included an overnight stay in hospital of at least one night (Figure 6) and 1015 attendances with no overnight stay (Figure 7). The results demonstrate that during this period there was a downward trend in the numbers of care home residents needing a hospital admission with an overnight stay or an attendance without an overnight stay. It has not been possible to obtain more recent data in order to know if the identified trend continued in the following years.

The NHS Trusts and PCTs care home residents were admitted to or attended are shown in Figure 8. The greatest proportion of the inpatient stays (56.1%) were at the University Hospital Bristol NHS Trust. The greatest proportion of hospital attendances not requiring an overnight stay were at North Bristol NHS Trust (64.7%).

Well over half of the admissions necessitating an overnight stay were classified as 'general medicine' (Table 2). The longest lengths of stay (over 100 days) were for those admitted under the specialties 'adult mental illness', 'general medicine', 'trauma and orthopaedics', 'neuro-surgery' and 'geriatric medicine'.

Table 2 Hospital admissions necessitating an overnight stay by medical specialty

Specialty	No.	%	Min. length of stay	Max. length of stay	Mean length of stay	SD
Accident and emergency	127	7.8	1	65	4.4	9.25585
Adult mental illness	41	2.5	4	211	56.2	45.65353
Breast surgery	1	0.1			2	
Cardiology	18	1.1	1	45	9.9	11.14022
Clinical haematology	1	0.1			2	
Colorectal surgery	21	1.3	1	17	4.5	4.65424
ENT	7	0.4	1	41	7.4	14.83079
Forensic psychiatry	1	0.1			79	
Gastroenterology	5	0.3	1	25	12.0	11.87434
Geriatric medicine	147	9.1	1	101	13.7	15.70948
General medicine	975	60.0	1	156	14.1	17.90801
General surgery	59	3.6	1	79	8.5	12.10631
Gynaecology	6	0.4	2	17	6.0	6.0
Maxillo-facial	2	0.1	1	4	2.5	2.12132
Nephrology	12	0.7	1	84	19.3	27.24746
Neurology	5	0.3	8	70	36.8	25.70409
Neuro-surgery	6	0.4	1	103	25.0	40.63988
Ophthalmology	8	0.5	1	4	1.8	1.16496
Paediatrics	3	0.2	1	5	2.3	2.30940
Paediatric neurology	4	0.2	2	12	5.5	4.50925
Plastic surgery	12	0.7	1	81	19.6	23.83450
Trauma and orthopaedics	114	7.0	1	231	20.2	26.08457
Upper gastrointestinal surgery	22	1.4	1	25	7.4	6.19943
Urology	26	1.6	1	54	8.1538	14.30159
Vascular surgery	1	0.1			7	
Total	1624	100%	1	231	14.2401	20.31991

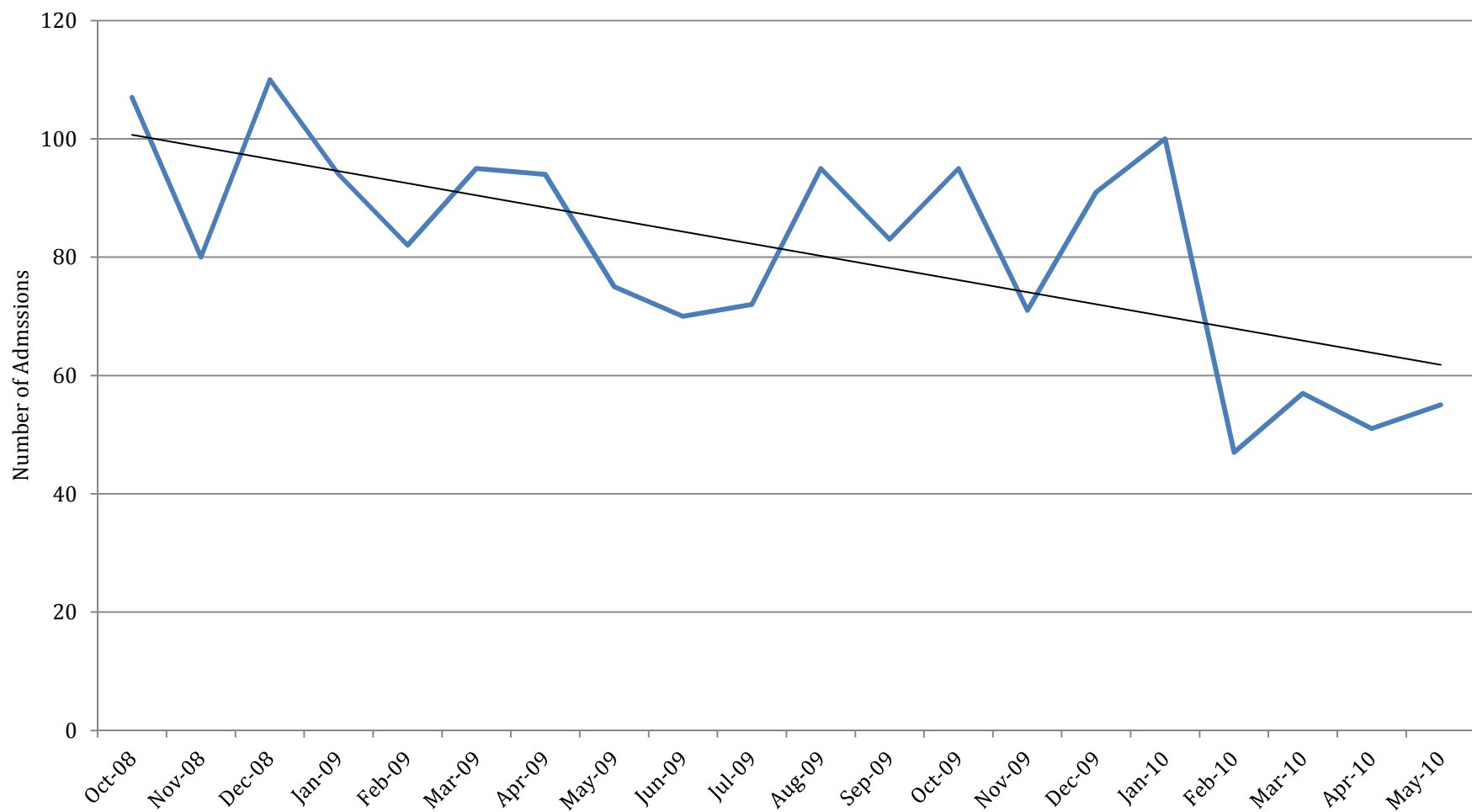
Hospital attendances not necessitating an overnight stay are shown in Table 3. These figures do include 207 A&E attendances; it is not clear whether these attendances are included in the separate A&E figures. Nephrology is the specialty with the highest number (494 attendances) and proportion (48.7%) of attendances, probably due to care home residents attending for dialysis because of renal failure.

Table 3 Hospital attendance by medical specialty

Specialty	No.	%
Accident and emergency	207	20.4
Cardiology	6	0.6
Chemical pathology	5	0.5
Clinical haematology	12	1.2
Colorectal surgery	3	0.3
Dermatology	7	0.7
ENT	3	0.3
Gastroenterology	15	1.5
Geriatric medicine	6	0.6
General medicine	108	10.6
General surgery	15	1.5
Gynaecology	2	0.2
Nephrology	494	48.7
Ophthalmology	45	4.4
Oral surgery	7	0.7
Paediatrics	7	0.7
Plastic surgery	11	1.1
Restorative dentistry	5	0.5
Rheumatology	2	0.2
Trauma and orthopaedics	9	0.9
Upper gastrointestinal surgery	2	0.2
Urology	42	4.1
Unknown	2	0.2
Total	1015	100%

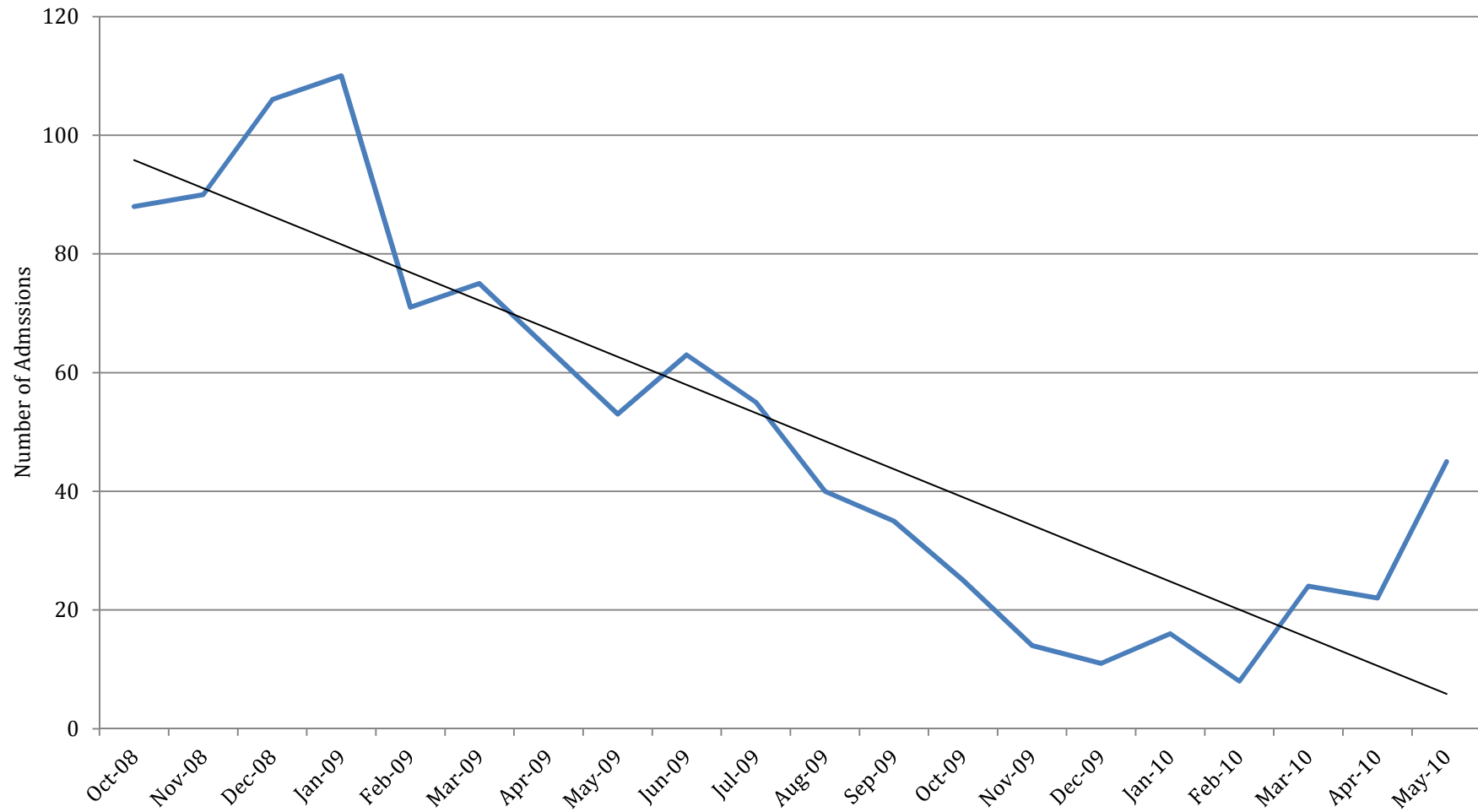
Accident and emergency attendances mirrored the same downward trend (Figure 8). Most of the A&E attendances (1710 attendances, 69.7%) were at the University Hospital Bristol NHS Foundation Trust. Most of the remaining A&E attendances were at the North Bristol NHS Trust (721 attendances, 29.4%); 8 (0.3%) were recorded at the Royal United Hospital Bath NHS Trust. Fifteen (0.7%) were recorded as being attendances at A&E departments outside of the region.

Figure 6 Number of admissions and admission trends for residents from BS postcode care homes: October 2008 to May 2010 with an overnight stay



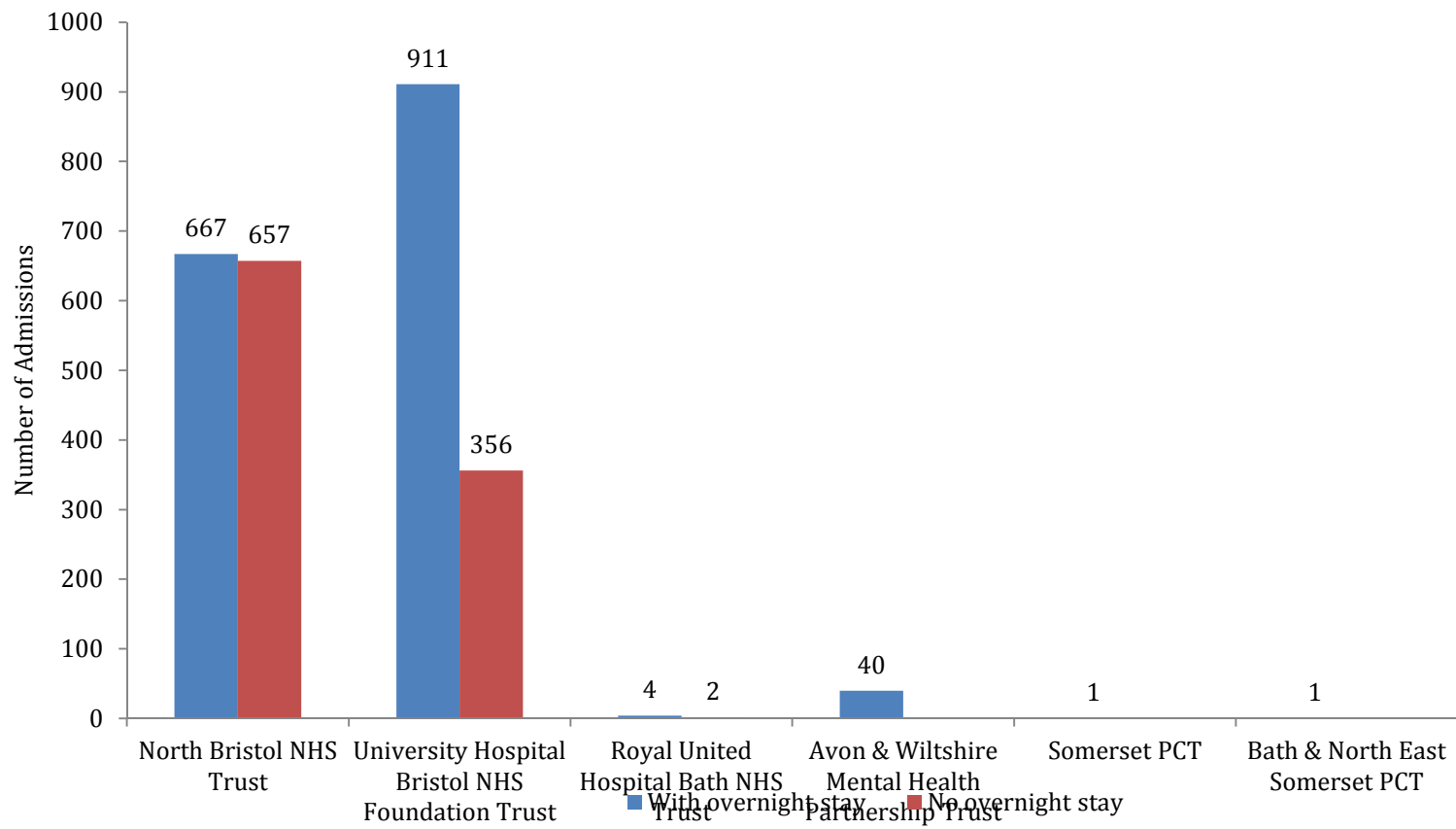
(N = 1,624)

Figure 7 Number of admissions and admission trends for residents from BS postcode care homes: October 2008 to May 2010 with no overnight stay



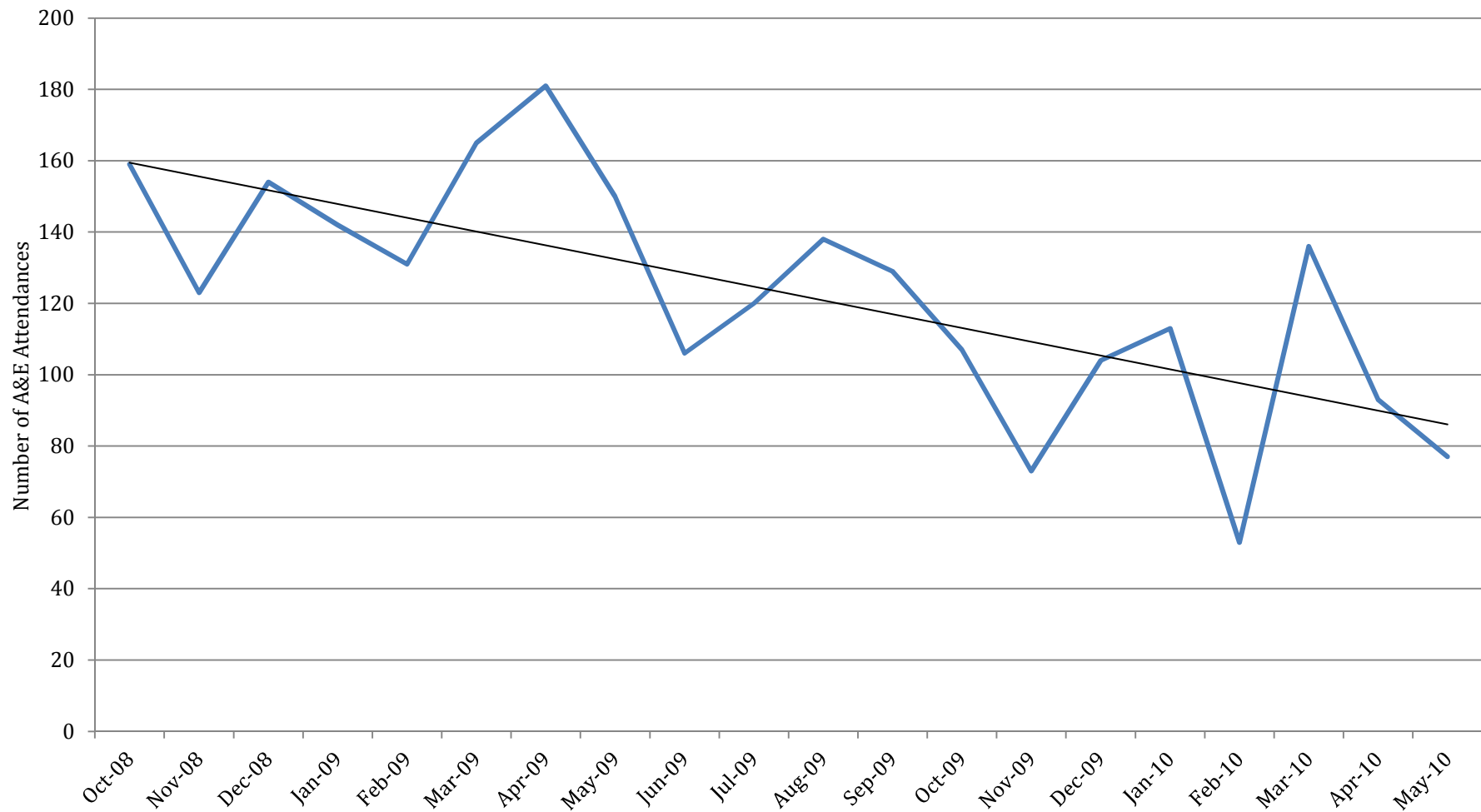
N = 1015

Figure 8 Number of admissions from BS postcode care homes by NHS Trust/PCT: October 2008 to May 2010



(N = 2,639)

Figure 9 Number of A&E attendances and attendance trends from BS postcode care homes: October 2008 to May 2010



N = 2454

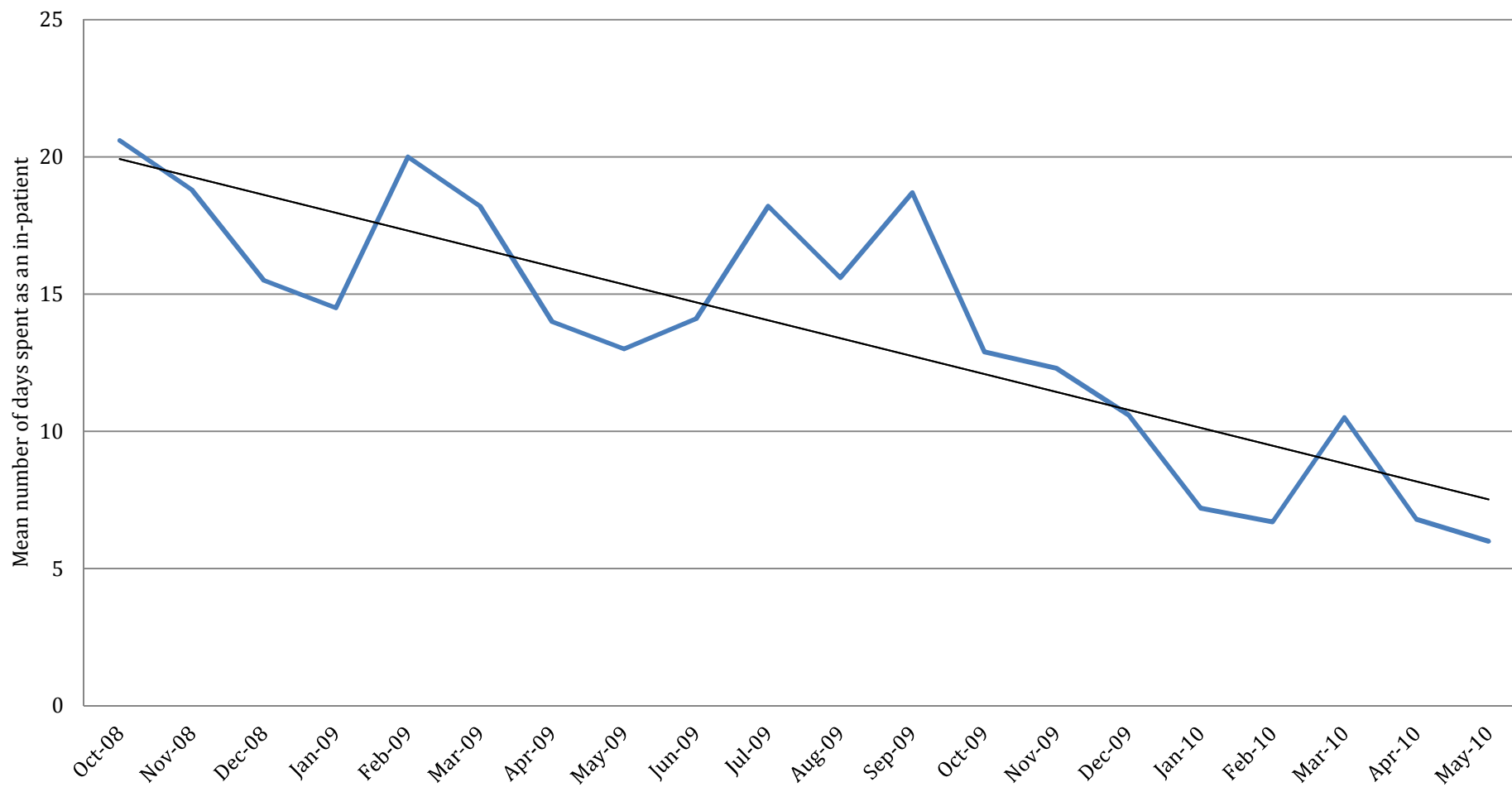
When the length of stay was compared by date the data showed not only was there a drop in the number of admissions but the length of stay was also reduced, suggesting that residential and care homes were better prepared to take individuals back at an earlier stage than they were previously (Table 4); Figure 10 illustrates the reduction in the length of stay. An analysis of variance (ANOVA) of length of stay by month demonstrated a statistically significant difference ( $F = 3.959$ ;  $p < .001$ ) between the mean length of stay by month over time.

Table 4 Admissions necessitating an overnight stay by month: October 2008 to May 2010

Date	No.	%	Min. length of stay	Max. length of stay	Mean length of stay	SD
October 2008	107	6.6	1	231	20.6	36.10333
November 2008	80	4.9	1	102	18.8	23.14697
December 2008	110	6.8	1	109	15.5	17.74268
January 2009	94	5.8	1	76	14.5	16.45110
February 2009	82	5.0	1	156	20.0	29.83307
March 2009	95	5.8	1	168	18.2	26.93253
April 2009	94	5.8	1	93	14.0	18.64033
May 2009	75	4.6	1	68	13.0	15.41583
June 2009	70	4.3	1	83	14.1	17.74746
July 2009	72	4.4	1	101	18.2	21.33762
August 2009	95	5.8	1	84	15.6	19.90868
September 2009	83	5.1	1	105	18.7	23.70007
October 2009	95	5.8	1	76	12.9	15.30378
November 2009	71	4.4	1	70	12.3	15.54231
December 2009	91	5.6	1	64	10.6	12.79254
January 2010	100	6.2	1	38	7.2	7.47291
February 2010	47	2.9	1	24	6.7	6.72342
March 2010	57	3.5	1	46	10.5	11.75049
April 2010	51	3.1	1	28	6.8	5.72918
May 2010	55	3.4	1	27	6.0	6.01222
Total	1624	100%	1	231	14.2401	20.31991



Figure 10 Mean number of days (with trend) spent as in-patients by BS postcode care home residents: October 2008 to May 2010



(N = 1,624)

The key informants acknowledged that the methods of collecting data on emergency admissions and A&E attendances was less than ideal, it was felt that a drop of admissions could be seen.

*'We would run data every month, on the number of admissions from known postcodes of all the residential and nursing homes and we got quite a good data set from that. We could split that down, we could look at percentages of admissions over a year. We also did it by hospital. Over about a two year period that I was actively working on it ... we saw a drop of 20% of admissions from residential nursing homes (key informant interview)*

However as key informants acknowledged, even if there can be shown to be a reduction in admission since the learning programmes were established, it would be difficult, probably impossible, to prove a causal relationship. In the real world of complex changing circumstances, variables cannot be isolated:

*'hand on heart I couldn't say that was down to the training course or the actions of (the PCT) ... I think it was a combination of everything because it's just impossible to know'*

Other forms of evidence do however also suggest an impact. Informants from specialist services, such as Rapid Response, who attended the learning programme as speakers reported increased use of their community based services as evidence of reduced need to use hospital services

*'after each visit, invariably the number of calls from that home to (the community based nursing team) would go up ... especially at night. So they would get more calls for advice' (key informant interview)*

There was a feeling amongst key informants and participants that the increased knowledge regarding medication, falls, infection control had a preventative impact, keeping residents in the home, and avoiding admissions to hospital. Here a member of one of the specialist services explains the impact of her work on the learning programme:

*'Definitely I think it's an excellent piece of work ... Our aim is to keep people out of Hospital ... On the training day ... (we explained) ... the resources in the community. Trying to make them understand that, okay, sometimes people do have to go in. But a lot of the time people can be better managed within their own Home ... So getting that message across really did help ... we did training on the course as well about the sort of medications and people falling and....that was really beneficial (key informant interview)*

#### Another key informant

*'... I think it was possibly in the summer when one of the nurses from that session had gone back (to the home after the training on infection control) and there was a patient with CDif and she was able to challenge one of the management with what she'd learnt and you know potentially things could be ... the fact that they had been to the session had potentially stopped an outbreak happening and certainly the management because obviously with CDif your patients can become really sick and unwell if not managed properly and could die as a result. (key informant interview)*

In the knowledge cafes, staff did not tend to refer directly to this issue and seemed not be aware of this underlying aim of the learning programmes and networks. When however the issue was raised, participants were quick to point out that the changes made to their practice was indeed likely to reduce the need for admissions. Examples related to changing practices in infection control, food and drink procedures, increased awareness of medication issues, wound care and management of skin conditions such as ulcers.

*'Greater awareness of hydration can prevent hospital admissions for people with UTIs, confusion. We manage residents' conditions better so can keep them in the home. We have a lady who is prone to UTIs, so we keep her hydrated and that should reduce likelihood of having to be admitted to hospital' (knowledge café participant)*

It was also felt that the increased contact with specialist staff meant they had other places to refer problems. Much of the action planning and the feedback on the action plans, discussed above, also demonstrates better preventative practices on aspects of care such as infection control and treatment of chronic conditions.

*'We have knowledge of, and access to other specialists such as the falls expert, we can phone or have her visit, knowing teams exist to support staff makes a difference (knowledge café participant)*

## The future

Participants in the knowledge cafes were asked to evaluate the learning programmes using a number on a scale of 1-10 to indicate how important they felt it to be that the learning programmes continue in the future. All but one person gave a 10 - one wrote 'a definite 10!' One person gave an 8. They were also asked to give their reasons for their view. These included: the need for new knowledge to accompany changing policies and ideas; the value of networking with colleagues; and the benefits of staff feeling valued and returning with renewed enthusiasm for their work.

On a scale of 1-10, how important is it that the learning programmes continue in the future? Why?

- *10: Nobody knows everything and there is always room for more knowledge. Things change so further information needs to be given*
- *10: To continue staff development and make them feel valued. Interaction with other staff from other homes*
- *10: Why – changes in practice, changes in staff experiences. Refreshing knowledge helps good practice*
- *10: Everyone has attended has come back enthused and says it needs to be carried on. Staff become proactive rather than reactive*
- *A definite 10: This type of training has practice relevance for everybody and is designed for practical use*
- *10: Wonderful well-presented course that provided evidence-based up to date knowledge and gave staff the opportunity to mix across all disciplines*
- *10: Relevant information that enabled staff to set 'practical' objectives that were relevant to practice and attainable*

(written responses from learning programmes knowledge café participants)

The participants at the evaluation event for the networks were also asked to evaluate the importance of the networks continuing into the future, using a scale of 1-10. The numbers were again high, but slightly lower than for the learning programmes, with two 10s, a 9, an 8 and a 7 being awarded. Networking and sharing ideas and knowledge were the main reasons given for the need for continued meetings, as well as to bring in homes who had not previously attended.

On a scale of 1-10, how important is it that the learning networks continue in the future? Why?

- 7 : to continue to bring care homes together, improving standards of care to all people. Maybe different subjects, unless things change within an area eg policy and practice
- 8 : because we can continue to share information and improve the care we give
- 9 : such a good opportunity to learn, network, swap information, get to know about other homes!!
- 10 : since coming to the network, I have not only learned lots, but now feel I can approach other homes that attend
- 10 : for homes who have not attended before
- Very important = 10. Networking and knowledge (including knowledge of changes eg policy, care etc is so important and it is part of motivation

(written responses from learning networks knowledge café participants)

It is not anticipated that the learning programmes will be funded to run again. It was hoped that the networks can continue, running themselves in terms of organising dates, venues, refreshments, with more limited continuing help from the university staff in contacting speakers.

A member of one of the current networks expressed her concerns regarding the difficulties of continuing if there was no support from the university and the current organisers.

*'The involvement of UWE gives the programme some credibility. (The organizer) knows everyone, who to contact as speakers. We don't know the most appropriate people' (knowledge café participant)*

The organiser reports that contacting the most appropriate staff as speakers is becoming increasingly difficult, under current processes of re-organisation:

*'Community staff now who only used to support residential care homes without nurses now will support nursing homes as well. So one of the ways that this programme has helped is having local speakers to the programmes, so that they can support or give contact numbers details to the staff in the care homes ... The negative side is getting everybody on board because of the enormous changes going on with the PCTs and the commissioning and social enterprises. The staff changes now are huge in the NHS ... so that's become more difficult.'* (key informant interview)

Other key informants also expressed their concerns over the sustainability of the groups with reduced levels of support.

*'I think (the groups) are very hard to sustain, because although they were made up of the homes that had completed the course ... and the homes themselves were supposed to be setting the agendas and agreeing how often they wanted to meet ... it's very hard to sustain something like that' (key informant interview)*

In North Somerset, it is anticipated that the leadership of the networks will be taken over by a community matron. This will provide sustainability for the work into the future.

In the following paragraph, the current organiser explains her vision for a new direction for care home learning:

*The programmes of Learning have set the scene for training to enhance care for older people in care homes. University facilitators have learnt much from working closely with care homes over the last three years. Although care home staff have enhanced the care they provide there is further development work needed to sustain learning gained and provide a more focussed leadership through development of expertise in particular areas of care. The current programmes of Learning have served as monthly topics in terms of awareness and updating. It has become obvious during these programmes that care homes need more development on specific areas of care to enable change management. Further work would strive to concentrate on certain topics that are of concern for NHS providers. It would also be important to set objectives through the exploration of cultures of care and the impact of this on change in care home settings*

The evaluation elicits the challenges and obstacles to both attending the programmes of learning and networks and also enabling dissemination to the whole care home workforce. Time and staffing levels are reoccurring themes for non attendance. Although it was not expressed by participants in the evaluation, the current organiser is conscious that having a new topic each month may have made it more difficult for staff to digest and disseminate one action plan, before another topic and action plan is set. At worst this could be a barrier to change and, at best, cause confusion through information overload over a short period of time. Change management takes time. With all the other challenges highlighted within this evaluation report, time for processes of change to be fully embedded needs to be taken into consideration in any future training or development with the care homes workforce.

In response to this evaluation, the project lead Tina Fear has created and disseminated new business cases for the support of 'champions' within care homes. The aim is to provide a less diluted approach to training, based within individual care homes and inclusive to all staff. The training would be able to focus on one topic, identified by individual care homes as needing sustainable change.

A champion course with website support could enable changes in practice through a focus on one area of care. This approach would link to Trusts through audits and a strategy for sustainable communications across the sectors. Champions would be supported and enabled to lead on one particular aspect of care, for example end of life care, medication, or dementia care. The champion would become the expert and accountable person designated for a particular area of care. They would be enabled to train and develop all staff within the care home to ensure best practice, and act as the named person for the specific area of care for residents and others involved in the residents' care.

## Conclusions

Demographic trends increasing life expectancy, together with long term policy changes moving care of increasingly needy people from hospital to community settings, have impacted on care homes and the skills required of staff working in these homes. Despite this changing context of care, there continue to be limited opportunities for care home staff to update and improve knowledge and skills.

The learning programmes and networks evaluated in this report are uniquely tailored to meet the needs of this sector. The many strengths of the programme include:

- the passion and commitment of the organizers – creating a positive, welcoming and safe environment in which good practice is celebrated and change encouraged without blame or condemnation
- the venues – basing the learning in a home provides a non-threatening and comfortable environment for participants, easily accessible, with drinks and food available
- the timing of the sessions – maximizing attendance by fitting within timetables of homes and staff with family responsibilities
- the involvement of everyone in a home – managers, nursing staff, care staff, cleaners, cooks, and other support staff learning together in an environment in which all roles are valued equally
- the relevance of the presentations – from well-informed expert speakers working in local health and social care roles, with lively and engaging presentation skills, geared to practical real improvements in care
- the interactive learning – enabling all participants from varying backgrounds and levels of expertise and experience to making an active contribution and believe in the importance of their role and their ability to make a difference
- the facilitation of sharing of ideas and experiences across homes
- the ownership of the folders and their continued use as a resource in the home
- the promotion of means of communicating learning from individual attendees to all staff in the home
- the action planning and feedback - of particular importance is the emphasis on and time and thought given to the process of action planning and feedback which ensures learning is transformed into immediate, practical and effective changes in practice of direct impact on quality of care for residents.

The model for the development of the initiative was one of partnership working, involving local authorities, PCTs and specialist services in a 'whole systems approach' to the development of the learning programmes and networks. This model was more successfully followed through in North Somerset. There are a number of possible explanations for this. There are a greater number of care homes in North Somerset, and they are more geographically concentrated. The nature of the local economy means care homes play a significant role in providing employment and staff are more likely to remain within the sector, although they may move around from home to home. This can impact on the value placed on training. Probably most significantly, the initiative has a longer history in North Somerset and there has been more time to develop actively collaborative relationships.

Despite a range of efforts made by staff involved, there was evidence of variable attendance and a suggestion that the homes most needing the learning were least likely to attend.

It is clear that the learning provided through the programmes and networks is relevant, practical, and presented in forms which facilitate changes in practice. The evaluation found evidence of the impact of the learning programmes on staff morale and expertise. There were also many examples of changing practices in the homes and resulting long term improvements in the quality of care. Enduring links were established between individual homes, and between homes and related community services.

Although would be hard to prove a direction causal relationship between hospital admissions and the training offered by the learning programme, the evidence suggests an impact. The statistical evidence demonstrates there was a reduction in admissions from 2008 to 2010. It was not possible to obtain more recent data to show whether the identified trend continued in the following years. There were many stories of changes in care practices, some which would be likely to affect admissions to hospital, for example practice relating to resuscitation, infection control, use of medication, and changes around eating and drinking.

The time in which the learning programmes have been developed has been one of extreme change in the organisation of the NHS and social care. These changes include the government's agenda giving GPs power over commissioning and changes resulting from reformation of commissioning and provider organisations into social enterprises. The effect of multiple and fundamental changes in commissioning and in provision of care have led to a situation in which it is very difficult to maintain relationships needed for the best functioning of the learning programmes. Locally many staff who have played a part in the learning programmed have changed roles.

There was support from all participants in the evaluation for the continuation of the learning programmes, should further funding be made available. It is hoped that the networks will continue but there was some skepticism over the ability of the networks to be self-sustaining, without some element of outside leadership and continued support.



## **Recommendations**

1. There evidence suggests there is likely to be a continued need for learning to up-date and up-skill staff in care homes, to maintain networking between homes and to link homes to changing community-based services.
2. Further consideration needs to be given to issue of attendance. Whilst many efforts were made here, there may be scope for more effective publicity and greater incentives to encourage all homes to send staff. See also recommendation 7.
3. The model of learning presented here is uniquely effective in engaging staff at all levels and in facilitating implementation within the homes. It is suggested that any further educational developments should be based on this model.
4. The care home learning networks are established but are likely to need continued support and leadership from within the health service to be sustainable.
5. There will need to be continued publicity to bring new staff and homes into the existing networks.
6. The experience from North Somerset provides a model of collaborative working. Consideration needs to be given to further development of this 'whole systems' approach in other localities
7. Consideration needs to be given to extending collaborative work to include the organizations providing care homes. This may increase the sense of ownership and be effective in improving attendance.
8. A consistent approach to collecting data around hospital admissions and A&E attendance would allow particular trends and problem areas to be identified. This would facilitate policies and protocols, identifying training and education needs so that residents can be care for and treated with greater effect within their homes.
9. The development of champions within care homes, enabled to train and develop all staff within the care home to ensure best practice, and act as the named person for the specific area of care for residents and others involved in the residents' care.
10. Further developments, such as the proposal for 'champions' working within care homes, require evaluation to be built in from the early stages to enable assessment of impact.

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## **Appendices**

## **Appendix 1: Key informants interviews – interview schedule**

Note: It is not expected that everyone will be asked or able to answer all of the questions

- What is your role?
- In what way are you involved with the programmes of learning for the care home and/or the care home networks?
- What do you see as the need for this programme?
- What kind of learning is most important for care homes?
- What are the barriers to learning for care homes? What challenges?
- Do you have any views to share on any of the following?
  - the venue
  - the speakers
  - the lecturers from UWE
  - the times/dates
  - the portfolios
  - the networks
  - the use of action plans
  - contact with staff outside of the sessions
- The overall aims of the Programme are to reduce admissions from care homes to hospital and to maximise quality of life for care home residents – are these aims being met?
- Are you able to give any examples of the care of the residents being changed/improved as a result of the programme?
- Do you have access to any statistics or examples of hospital admissions being avoided?
- Key issues in the development of the initiative have been the importance of partnership working and creating sustainability. Are these being achieved?
- Are there any barriers preventing care homes from accessing the learning programme? What facilitates this process? What hinders it? What are most important issues in getting homes and staff to participate?
- What improvements could be made? What else could be done?
- Anything else?

## Appendix 2: Knowledge cafe schedule for learning programmes

1. Think about your experience of attending the learning programme and how it has affected you and the home in which you work. With this held loosely in mind, choose a picture. (Each talks about picture and what is said is written down)
2. H form evaluation 1: the learning programme

<i>What the things that make the learning programme a success?</i>	<i>What are the purposes of the learning programme, from your point of view?</i>	<i>What are the things that not so good about the learning programme?</i>
	<i>What could be changed to improve the learning programmes?</i>	

3. H form evaluation 2: learning and application

<i>What have you learned from the coming to the learning programme? (as many examples as you can think of)</i>	<i>What have you learnt that you have been able to take back into your work? As many examples as you can think of)</i>	<i>What methods have you used to make sure others at work benefit from what you have learned?</i>
	<i>What makes it difficult to share what you learn with others in the home? What stops you putting your learning into practice?</i>	

4. The future

On a scale of 1-10, how important is it that the learning programmes continue in the future? Why?

### Appendix 3: Knowledge cafe schedule for learning networks

1. Think about your experience of being in the Network and how it has affected you and the home in which you work. With this held loosely in mind, choose a picture. (Each talks about picture and what is said is written down)

2. H form evaluation 1: the network

<i>What the things that make the network a success?</i>	<i>What are the purposes of the network, from your point of view?</i>	<i>What are the things that not so good about the network?</i>
	<i>What could be changed to improve the networks?</i>	

3. H form evaluation 2: learning and application

<i>What have you learned from the coming to the network? (as many examples as you can think of)</i>	<i>What have you learnt that you have been able to take back into your work? As many examples as you can think of)</i>	<i>What methods have you used to make sure others at work benefit from what you have learned?</i>
	<i>What makes it difficult to share what you learn with others in the home? What stops you putting your learning into practice?</i>	

4. The future

On a scale of 1-10, how important is it that the networks and the programmes continue in the future? Why?

## **Appendix 4: Notes from knowledge café**

South Gloucestershire Care home learning programme  
3 May 2012

This event was held in the afternoon, following on from a learning programme session. It ran from 12.30-3.00. Lunch and other refreshments were provided. It was held in the lounge of one of the local care homes. Four people attended, from three homes.

### **Exercise 1**

Participants were asked to 'think about your experience of attending the learning programme and how it has affected you and the home in which you work. With this held loosely in mind, choose a picture'. Each person selected an image from a large collection laid out on tables. The pictures were attached to page from a flip-chart and each talked in turn about their picture and why they chose it. Notes were taken.

Themes arising:

- Feeling frustrated when there are things which could be done at work, but not having enough knowledge of skills. 'Residents look to you for help and support. Sometimes I don't know enough.'
- Excitement and enthusiasm for the training. (A manager says) 'everybody came back full of enthusiasm. They really enjoyed it. They all learned something, they were enthused and exuberant. They were willing to share what they learned.'
- The need to use the right tools for the job eg the right dressings for a wound. Can do more harm than good if don't use the right tools.

### **Exercise 2**

Participants were given a new page from the flip chart with four questions in 'H' formation (see appendix 1). They were asked to note their responses, individually, on post-it notes and attach these to the flip-chart. These were then discussed, with notes taken.

*What are the purposes of the learning programme, from your point of view?*

- The purpose of the learning programme I think is to interact with others and learn other's ideas and possible improvements
- To give more information into important subjects within care
- To give the junior staff the opportunity to learn and realise they are very much an important part of the team
- For senior staff to realise changes do occur and we must be on top of this

*What the things that make the learning programme a success?*

- Care staff become more aware of the reasons why procedures and policies are in place
- Communication with each other
- A wide range of people attend so you can gain information from all perspectives
- Remembering that the client knows more than we assume
- You get to meet new people with different experiences that you can learn from as well as getting important information from specialist speakers
- The carers learning more knowledge and confidence to make positive suggestions or changes to the home
- Learning what we do already know

- Comfortable room and comfortable chairs, not having tables and chairs which would make it feel like school
- Tina makes people feel relaxed and comfortable about participating. Tina guides people to see other ways of making changes and makes change manageable

*What are the things that not so good about the learning programme?*

- Sometimes it is hard to follow things if the speaker is talking at a level above you, feel reluctant to ask questions if the jargon is difficult
- The session was quite difficult today for someone without nursing training
- The parking here is quite difficult.
- When notes are being passed on to the next person, it's like Chinese whispers, so could lead to false information
- Not enough people come. There were only 6 today. It is a big commitment but homes need to commit to it

### **Exercise 3**

Participants were given a new page from the flip chart with another set of four questions. Again, they were asked to note their responses, individually, on post-it notes and attach these to the flip-chart. These were then discussed, with notes taken.

*What could be changed to improve the learning programmes?*

- May be good to have some handouts or some web addresses for staff to make a folder for themselves, even a smaller folder for each student (in addition to the folder for the home as a whole)
- Not so much changed, but a specific requirement that one or two senior people come with another member
- The action plans only have the points that the last person thinks were important but there may have been others, print-outs could be given
- Notes from training to be given to the home as everyone picks up different aspects of things
- It can sometimes be difficult to remember everything covered. Maybe we could have some handouts with good point to take back to the care homes with you to show others
- Speakers could learn more about the group, who is there, and gear the level of the information given to the group

*What have you learned from the coming to the learning programme? (as many examples as you can think of)*

- Medication can be the cause of falls. Also so can high blood pressure
- Maintenance of equipment re infection control
- Resuscitation procedure
- Infection control
- BMI
- The importance of food, the effects of poor diet, and involving cooks more
- Diabetics and the importance of 'normal' diet that is healthy and well-balanced
- Importance of communicating with residents
- Being careful with medication, how to administer, record-keeping etc
- Staff to be aware of the effects of medication, what drugs are for, the interactions and side effects



- Identifying which dressing to use with each wound

*What have you learnt that you have been able to take back into your work? As many examples as you can think of)*

- Ways of making it easier for people to eat and drink. For example, For people with dementia, we are getting plates in primary colours which means they can see their food
- Sometimes the way the resident behaves is a reflection of the way staff behave
- Emergency trolleys. We now have two emergency trolleys, one on each floor, so all the equipment to deal with emergencies is on one place and can easily be moved around. We check the trolleys once a week
- Rhesus status
- Chronic conditions
- BMI: using height and weight to calculate, staff are now more aware what it should be. We are going to put bowls of fruit in the conservatory for residents
- Information from others about different subjects eg communication, medication, wounds
- Always look at the background before you try to solve a problem
- A more holistic approach to wound care eg diet affects wounds
- We find out more about backgrounds of residents and put this in the care plan, to understand more about for example challenging behaviour. We ask relatives to give a history of the resident.
- With a specific resident, whose condition was not improving, listening to what we learned, we decided it was time to get the GP in

*What makes it difficult to share what you learn with others in the home? What stops you putting your learning into practice?*

- Staff not wanting to learn.
- Shortage of staff therefore no time to pass on information
- It's difficult to find the time sometimes to discuss points unless one particular thing comes up
- If you pass the information on to one person, they can then pass it on to another and little bits can get changes
- Language barrier
- Time
- sickness

*What methods have you used to make sure others at work benefit from what you have learned?*

- We have a notice-board in the staff room which we have all sorts of information from this programme on
- The folder for the training is in the staff office for everyone to read
- Actioned things! I will take knowledge back from today and contacts

Finally participants were given a fourth sheet of paper and again asked to record responses on post-its

*On a scale of 1-10, how important is it that the learning programmes continue in the future? Why?*

- 10: Nobody knows everything and there is always room for more knowledge. Things change so further information needs to be given
- 10: To continue staff development and make them feel valued. Interaction with other staff from other homes

- 10: Very important. The information gained can be vital and an informal meeting can help gain confidence
- 10: Why – changes in practice, changes in staff experiences. Refreshing knowledge helps good practice

## **Appendix 5: Notes from knowledge cafe**

Bristol Care home learning programme

10 May 2012

This event was held in the morning, running from 9.45 to 13.00. Lunch and other refreshments were provided. It was held in the lounge of one of the local care homes. Six people attended, from three homes, one of which was for people with mental health problems.

### **Exercise 1**

Participants were asked to 'think about your experience of attending the learning programme and how it has affected you and the home in which you work. With this held loosely in mind, choose a picture'. Each person selected an image from a large collection laid out on tables. The pictures were attached to page from a flip-chart and each talked in turn about their picture and why they chose it. Notes were taken.

Themes arising:

- Medication. Before the training we willingly used PRN instructions from doctor to give medication. Now we think of the client as an individual person. We don't want to sedate them, we want people to be themselves, to be animated, not what we try and make them to be. Not half asleep, watching children's TV
- Falls session: need to clear spaces to be safe environments for people with dementia, poor eyesight
- Aware of people's past, their lives outside before they came to the home, it could be us. The need for dignity
- Choices eg re drinks not to assume because you like a cup of tea in the afternoon that everyone does, make choices available
- Involving families
- Always new things to learn

### **Exercise 2**

Participants were given a new page from the flip chart with four questions in 'H' formation (see appendix 1). They were asked to note their responses, individually, on post-it notes and attach these to the flip-chart. These were then discussed, with notes taken.

*What are the purposes of the learning programme, from your point of view?*

- Educational, informative
- Enhancing skills
- Focus on good practice
- Evidence based practice
- Up to date knowledge
- To give/provide quality care to client / resident
- Good reputation
- Learn, refresh and gain new knowledge,
- Share
- To learn new info and pass on to colleagues and relate to practice
- Learn from other homes
- Spread new info around the team
- Involve all staff housekeepers, cooks, who are just as important, but not often involved as stakeholders. Is a really valuable part of the training. If they understand why they are

doing what they are doing and if we are all working together. Great points contributed from other teams eg housekeeping. They don't usually have the opportunity to learn or contribute.

- To improve reputation of home, support compliance, and records of training for home and for registered nurses required to do CPD

*What are the things that make the learning programme a success?*

- Talking and discussing as a group
- Learning more
- Group discussion
- Visual aid
- Share knowledge and idea
- Break in between parts of course, short sessions for which easier to remember
- Relaxed
- Informal
- Times and locations
- Informal and relaxing atmosphere
- The recap before each session
- Interesting and engaging speakers
- Sessions built around our working experience
- Topics relevant to the work
- A lot of information has been able to be implemented into work settings
- Share info from previous session
- Involved everyone, the cook, the housekeeper
- Time 1-3 not competing with traffic, childcare
- Creating discussions
- Encouraging all staff members to attend, something for everyone
- Folder – staff knew where to find information, knew what was expected of them. The folder was a 'bible', people didn't forget it, took it seriously, could feel involved even before attended and be able to participate
- Staff looked at the list of topics and decided which to attend.
- No limit on numbers, space allowing, 4 came sometimes
- Recap on last time was useful
- People who attended spoke to the person going the next time and passed on what happened so they could feed back
- Very interactive
- Every objective as applicable, going back to improve practice in the home
- Reminder email prior to study day
- It has been implemented
- People enjoyed meeting others from other homes and the interaction
- Level excellent for majority, support workers didn't feel it was over their heads

*What are the things that not so good about the learning programme?*

- Lovely venue (lounge at one of the homes), but could become crowded
- Sessions too short
- Time consuming
- Sessions too long (boring)
- Small point but sometimes registered nurses not stretched, as pitched to whole group

*What could be changed to improve the learning programmes?*

- Maybe each topic have more than one session giving others the opportunity to attend
- Some learning relating to mental health issues. Mental capacity legislation, safeguarding, deprivation of liberty

### Exercise 3

Participants were given a new page from the flip chart with another set of four questions. Again, they were asked to note their responses, individually, on post-it notes and attach these to the flip-chart. These were then discussed, with notes taken.

*What have you learned from the coming to the learning programme? (as many examples as you can think of)*

- Infection control
- Importance of correct dressing / wound care
- Identifying stages of wound healing
- Importance of disposing of dressing packs even if not used
- New information – barriers to good nutrition – asked chef to offer small fruit portions, more tempting, and fortifying meals and ways of improving care by offering more choice to residents
- Diabetes – discussion around hypos
- Regular checks – feet
- When to give lucozade – increase blood sugara
- It is important to reflect on own practice. There is always room for improvement in the way we work
- Medication
- Looking at polypharmacy
- Importance of maintaining good medication records
- Our responsibilities of making sure that it is given in its correct licensed form
- The importance of maintaining regular times of meals
- Hydration
  - The importance of having a culture where hydration is important
  - Offering interesting alternatives
  - Why hydration is important
  - Prevention better than cure

*What have you learnt that you have been able to take back into your work? As many examples as you can think of)*

- Encouraged staff to use correct infection control methods eg hand washing, use protective equipment eg gloves properly
- Been more aware of hydration, making sure staff are helping residents to maintain good hydration
- Body map used for residents with pain. Used to highlight areas of pain, list medication, and can alert to new pain if new areas mentioned
- Dehydration
- Disposable resuscitation masks. After study day on emergency situations, we purchased two more pocket masks for cardiac arrest situations, to enable staff to give mouth-to-mouth resuscitation. It is on our agenda to review procedures and staff training and re-familiarise staff

- Hand washing signs
- Encourage fluid and food intake
- Has changed the way we look at medication. We cast critical eyes over prescribing and check for duplication and whether residents still need medication they have been taking for many years
- We review every six weeks
- To ask GPs to review medication
- Raised questions about controlled drugs, who can give these, who cant
- Only to use PRN medication as a last resort. Although doctor might say PRN, now more aware can try non-pharmacological solutions
- Evidence based practice
- Nutrition – cut and display food to be more presentable portion sizes
- How to fill in food charts
- Use of good feeding techniques
- Use of eating aids – introduced new bowls with red rims for people with poor eyesight

*What makes it difficult to share what you learn with others in the home? What stops you putting your learning into practice?*

- Time
- Getting doctors and psychiatrists to mend their ways – they should attend too
- Some of our professionals not so willing to change

*What methods have you used to make sure others at work benefit from what you have learned?*

- Hopefully change policies and feedback in staff meetings
- Build up articles etc on relevant topics in our info file
- Audit of infection control knowledge
- 1:1 meetings
- Shift handovers – talked about in handover, even when people didn't themselves attend
- Team meetings
- Open access to the folder
- Distribution of information
- Share all information from the sessions with colleagues
- Folder available, everyone knows where it lives
- Communication book
- Discussion handover
- Team meetings
- 1:1 supervision sessions
- General discussion
- Pass on to residents and families

Finally participants were given a fourth sheet of paper and again asked to record responses on post-its

*On a scale of 1-10, how important is it that the learning programmes and the programmes continue in the future? Why?*

10

Enhance skills

Provide training, education

Promote good practice

Update all staff practice

Offer opportunity to share  
Information and networking

10

Enables information to be shared  
Evidence-based best practice  
Networking  
Creates team communication and discussion  
Everyone has attended has come back enthused and says it needs to be carried on  
Enables all staff to be involved  
Staff become proactive rather than reactive

10

To update knowledge  
To share knowledge and ideas amongst different levels of staff  
To provide quality care  
A definite 10  
This type of training has practice relevance for everybody and is designed for practical use

10

Wonderful well-presented course that provided evidence-based up to date knowledge and gave staff the opportunity to mix across all disciplines  
Relevant information that enabled staff to set 'practical' objectives that were relevant to practice and attainable

Discussion re hospital admissions theme

Greater awareness of hydration can prevent hospital admissions for people with UTIs, confusion. We manage residents conditions better so can keep in the home. We have a lady who is prone to UTIs, so we keep hydrated and that should reduce likelihood of having to be admitted to hospital

Infection control: We discard sterile dressings, used to try and save

Diabetic session can prevent admissions

We don't have many admissions anyway

Knowledge of and access to other specialists eg falls expert, can phone or have visit, knowing teams exist to support staff

**Appendix 6: Notes from knowledge cafe**  
North Somerset Care home learning programme  
17 May 2012

This event was held in the morning, running from 9.45 to 13.00. Lunch and other refreshments were provided. It was held in the lounge of one of the local care homes. Four people attended, from three homes and one domiciliary care organisation.

**Exercise 1**

Participants were asked to 'think about your experience of attending the learning programme and how it has affected you and the home in which you work. With this held loosely in mind, choose a picture'. Each person selected an image from a large collection laid out on tables. The pictures were attached to page from a flip-chart and each talked in turn about their picture and why they chose it. Notes were taken.

Themes arising:

- As a manager I can see what I want to do to make life better for the residents, but I always come up against things that stop me. Staff are reluctant to change. I can see through it all, to where I want to go, but it is hard to get there.
- Love, caring. That's the nature of our work – caring.
- Sometimes we forget how much people in the home have given up – their possessions, their pets, a whole lifetime of accumulated possessions
- The philosophy of choice is sometimes contradicted by needs other staff from health or social work want to meet.
- You have aims but often you go backwards and forwards, sometimes a long way backwards

**Exercise 2**

Participants were given a new page from the flip chart with four questions in 'H' formation (see appendix 1). They were asked to note their responses, individually, on post-it notes and attach these to the flip-chart. These were then discussed, with notes taken.

*What are the purposes of the learning programme, from your point of view?*

- To cover all different aspects of training in the care setting
- Linking this to different care settings
- Exploring different types of training
- To enhance knowledge
- To improve quality of care
- Enables me to feed back new ideas to my team
- Hear other people's experiences
- To improve my knowledge, talk to people from other homes. Share information. Learn of new methods
- To enhance my knowledge to share ideas

*What the things that make the learning programme a success?*

- Speakers who are involved and working with that programme
- It means we have current and up to date information
- Making different staff think about subjects
- Opening up discussion in the home about the session



- Improving awareness
- Opening up more training opportunities
- Communicating with all providers / people attending
- Competent speakers
- Discussing situations in the group
- Well run
- Having other people's views of experiences
- Meeting new people
- Free
- Relaxed atmosphere
- Consistency in venue and familiar faces enabling you to open up to talk more easily
- Variety of topics, delivered well
- Tina ever so helpful. Absolutely brilliant. Arranged topics we asked for
- (speakers are passionate, really know what they are talking about, are working in that role, are people in the real world, could answer questions from experience)
- Relaxed venue, comfy chairs
- The timing is good, the early finish fits well with shifts and childcare
- Action plans mean the staff have to sit and listen, they have to come back with something.
- Staff volunteer to attend topics they are interested in. Some come on their days off. It is ideal if they choose to come, they are keen and they want to learn
- The folders – people have to read them in order to be ready to answer questions about last time. It is good as the folders get used. There is good literature in the folders

*What are the things that not so good about the learning programme?*

- In the first few sessions N Somerset staff made remarks that were not positive and made me feel uncomfortable about attending. (Threatening not to fund the homes if they did not attend. The programme wasn't sold on the basis of getting funded, or being inspected, it was training. This was not constructive or positive
- They were on the phone in the sessions, phoning homes who hadn't attended. It was rude to the speakers. We were relieved when they left part-way through the session
- Threatening that people must attend all sessions, but in the real world residents come first
- Advertising is low key, people heard through other people

*What could be changed to improve the learning programmes?*

- Ensuring that the speakers will attend on the day
- More homes to attend regularly
- Some sessions I wish were longer. The dementia one was very relevant and very well delivered
- More on dom care – I have told others about it from domiciliary care, they want to come
- Ask attendees what subjects they would like to have covered if they feel that they need more knowledge on them
- Unable to think of any way to improve

### **Exercise 3**

Participants were given a new page from the flip chart with another set of four questions. Again, they were asked to note their responses, individually, on post-it notes and attach these to the flip-chart. These were then discussed, with notes taken.

*What have you learned?*

- Feeding ideas, thickening drinks
- Medication licensing
- Dementia training
- Not to talk to someone whilst eating as increases risk of choking
- Helping resident with dementia
- Nutrition and swallowing
- Seeing how the elderly view the world
- Different ways people express their needs
- Identifying individual needs, looking at care plan with residents and families
- Specialist topics – up to date information to use
- Identifying training needs for the staff

*What have you learnt that you have been able to take back into your work? As many examples as you can think of)*

- Caffeine being negative as fluid intake and to count gravy etc as fluid intake
- How to help residents interact
- Different ways to display information
- How to present food to a resident with dementia, what colours to use, red plates make food more visible
- Developing training ideas and using community resources
- Increasing all staff knowledge around different subjects ie falls, risky swallow, dementia
- After the session on feeding, where we fed each other with yoghurt, I made my staff do this. I had them do it badly and properly and experience what it is like.
- I got people to suck on a sweet and work out what they needed to do to swallow
- Identifying residents that would benefit from community services available. A gentleman resident in the home was tube fed. After the session with the SaLT team, we brought them in to the home and they said the man could swallow. We gradually built up his eating and now he eats one meal a day. It is a huge change in his life. His mouth is cleaner and his breath fresher. He can't speak, after a stroke, but he could say he was thirsty and now we give him drinks.
- A resident had a cough and was on antibiotics. In the feeding session we heard a cough could be caused by crumbs of food. I never would have thought of that, none of us did. We brought the nurse into the home for a visit and now the cough has gone.
- Eg of challenging behaviour session. I sent a member of staff as part of her supervision. She had problems, but is now a changed person.
- From the tissue viability session we have started to use the cards to grade pressure areas. We put these in the resident's room and staff and relatives can see.
- CQC came to the home and asked staff questions. I had just passed on my learning from the risky swallow session: she was very impressed at the way they all could answer her questions
- I brought people I have met in the sessions into the home. We used the continence service to assess a resident. She used ultrasound and found an issue of 'doublevoiding' which is not resolved.
- We brought in the Falls specialist and a dementia specialist to provide training in-house for staff
- We avoid pureed food if possible and we learned people with to be able to recognise what is on their plate as food. We learned we can ask the chef to use moulds to re-shape pureed food.

- We learned to make the environment for people with dementia to look as much as they would expect – eg the bathroom to look like a bathroom. We also took mirrors out as people with dementia don't recognise themselves and may feel someone is there
- A member of staff asked to take on the role of dementia champion

*What makes it difficult to share what you learn with others in the home? What stops you putting your learning into practice?*

- You only get the feedback that they choose to feed back to you
- Staff being interested, staff attendance
- Some staff who have attended do not always pass on the information to explain what they have learned or what ways we could improve on
- Time resource for staff, workload for manager

*What methods have you used to make sure others at work benefit from what you have learned?*

- Staff meetings
- Supervision
- Talking to the manager
- Changing medication round
- Discussions at team meetings
- Discussions at one to one supervision
- At times discussing in the community
- Team meetings
- Practical activities ie feeding each other
- Supervisions
- Having professionals into the home
- Sending others to the training
- Folder on display
- One to one sessions
- Group sessions at staff meeting
- Notice boards

Finally participants were given a fourth sheet of paper and again asked to record responses on post-its

*On a scale of 1-10, how important is it that the learning programmes and the programmes continue in the future? Why?*

8

Important to identify homes that would benefit and encourage them to attend with N Somerset support

To ensure good awareness for homes about community services and how to use them

Up-to-date knowledge around chronic ongoing diseases

So that the programme can keep all staff up to date

10

Good to talk to other homes and share information

Have up-to-date information

Good contact details with professionals

Feel supported

Learn new skills

10 very important

So others can be benefiting from it  
To allow time for other sessions to be delivered  
Continuing development  
Real people delivering not just someone stood talking  
At an understandable level  
No writing that puts people off  
Environment encourages people to talk and engage  
To keep updated with changes and current practices

10 very important for continuing professional development  
Sharing ideas in the group  
Keeping up to date with new legislation etc  
Learning new ideas

**Appendix 7: Notes from knowledge cafe**  
North Somerset Care home learning network  
29 February 2012

This event was held in the morning, running from 9.45-13.00. Lunch and other refreshments were provided. It was held in the lounge of one of the local care homes. Seven people attended, from five homes, one of whom was a student nurse who had not attending any network events.

**Exercise 1**

Participants were asked to 'think about your experience of attending the care home learning network and how it has affected you and the home in which you work. With this held loosely in mind, choose a picture'. Each person selected an image from a large collection laid out on tables. The pictures were attached to page from a flip-chart and each talked in turn about their picture and why they chose it. Notes were taken.

Themes arising:

- Focus on person-centred care, looking beyond what you see to the history of the person and the whole person they are. Treating people individually and holistically as a traumatic time in their lives
- Good communication between care homes, helping each other, leading to improved standards of care. Sharing information, problem solving together, bringing problems to the network
- Feeling engulfed sometimes
- Useful knowledge
- Support with Provider Compliance Assessments and CQC expectations

**Exercise 2**

Participants were given a new page from the flip chart with four questions in 'H' formation (see appendix 1). They were asked to note their responses, individually, on post-it notes and attach these to the flip-chart. These were then discussed, with notes taken.

*What have you learned from coming to the Network?*

- Better knowledge and understanding of a topic, able to share with staff at our home
- Ability to share information and ask other homes for help
- How to share information with other homes
- More about what's on offer in my locality and who to approach re issues in the home eg developed a working relationship with the community dietician
- DoLs training and contact most valuable
- Role of Rapid Response team

*What have you learned that you have been able to take back into your work?*

- Lots of topics covered over the years: dementia, diabetes, footcare, woundcare, mental capacity, fall to name but a few
- Dementia
- Strokes, footcare, dementia and loads of stuff and roles of community teams
- How to deal with wounds (easier to recognise sores and grade)
- Hydration ideas – not necessarily needing to drink more but also types of foods eg jellies, more fresh fruit, ice cream, sorbets. Were in a rut - used to just offer orange

squash, now provide alternative squashes. All patients are given caffeine-free coffee. Use cream instead of milk if patients are under-weight

- Assessment for falling, if a patient falls, then can phone the specialist. Good to go in when specialist is looking at to give ideas re slippers, possible need for walking frame
- Dietician showed how to do MUST (Malnutrition Universal Screening Tool). Can use score to contact GP, who will then decide if patient entitled to supplements or should be referred to the dietician

*What makes it difficult to share what you have learned?*

- Not enough time
- Time makes sharing difficult
- Only time
- Financial restraints eg at catheter training session – the trainer had wonderful trays and other equipment, we wouldn't have the funding for that
- Time restraints and financial restraints. We would like to send all the staff, but we cant afford to release them and they don't want to go in their own time
- Time – sometimes

*What methods have you used to make sure others at work benefit from what you have learned?*

- Group meetings, tutorials, cascading information down
- Sharing knowledge learned at staff meetings
- Carried out a micro-training session that used activities carried out at network meetings on dementia / person-centred care (all staff attended for whole day, used hand-outs and photos from the session)
- The training log and action plan sheets are useful for a quick informal discussion over coffee or at staff meetings
- Made other members of staff who came to the meeting pass on their knowledge
- Put stuff on notice board, talked with staff who attended in team meetings
- Disseminated MUST to other homes in Trust as well

### **Exercise 3**

Participants were given a new page from the flip chart with another set of four questions. Again, they were asked to note their responses, individually, on post-it notes and attach these to the flip-chart. These were then discussed, with notes taken.

*What are the things that make the network a success?*

- Communication, tutoring in a variety of subjects asked for by the network team
- Meetings are about topics that are chosen by us as areas we need help with
- The topics are chosen by us and its what we feel is important
- Good speakers (who know their stuff; we find out the roles exist)
- Location and timing is practical for busy managers (short time periods 9.45-12.00; local means can be called back in an emergency)
- Networking has proved to be valuable in improving the service
- Listening and learning about how other care homes work

*What for you are the purposes of the network?*

- Audit tool to show in inspections

- To share information with others (can ask for help when you know someone personally and they are not just a name)
- Share ideas/information. Makes you realise that you are not alone / isolated. Establish relationships
- between the homes, instead of being in competition. Feel confident to ring people and ask for information
- share information and learn more about things we need help with
- To develop knowledge, get people talking
- Encourage relationships between outside professionals and care homes
- Learning new things
- Gaining knowledge, networking, getting to know people and gaining contacts

*What are the things that are not so good about the networks?*

- I keep falling off the email lists
- Last minute changes to meetings or topics
- Need to know in advance to plan into off-duty
- Speakers not turning up (when ill, but we could have met anyway and had discussion)
- Cancellations – when Mount Elton site was closed due to sickness (but could have moved to alternative)
- Speakers are sometimes repeated but positive role over 12 month period
- Considering how many homes are in Clevedon, need more to participate
- Not as organised as it could be

*What could be changed to improve the networks?*

- Need someone constantly at the helm – organising, since less UWE input there have been more cancellations. Managers need 'outside' help (have other priorities)
- Need more homes to participate (some came once or twice, then not again)
- More homes to take part
- Some homes are still not taking part; without a lead it is difficult to organise meetings
- More information on what the speaker will be covering in detail

Finally participants were given a fourth sheet of paper and again asked to record responses on post-its

*On a scale of 0-10, how important is it that the networks continue into the future? Why?*

- 7 : to continue to bring care homes together, improving standards of care to all people. Maybe different subjects, unless things change within an area eg policy and practice
- 8 : because we can continue to share information and improve the care we give
- 9 : such a good opportunity to learn, network, swap information, get to know about other homes!!
- 10 : since coming to the network, I have not only learned lots, but now feel I can approach other homes that attend
- 10 : for homes who have not attended before
- Very important = 10. Networking and knowledge (including knowledge of changes eg policy, care etc is so important and it is part of motivation

*What messages would you like to give to others about the needs of care homes, their staff and residents?*

- Staff should have more money for the job that they do. Caring is hard work but very rewarding
- Would love to send a lot of staff. Make people aware of how useful it is to do networks and build up contacts
- In an ideal world we would be able to send all staff on every training available but not possible as not enough funding
- Importance of having time to attend training days and learning opportunities
- Training / learning / networking is an essential part of giving good care / practice and leads to a motivated workforce
- Other homes – meetings are most valuable, would explain examples of what we have got out of the meetings. Staff – encourage to attend, will see for themselves. Residents – newsletters
- Importance of having good staffing levels to provide better person-centred care
- Staff do a fantastic job and deserve more pay
- Residents need more one-to-one care but time constraints don't allow it



**Appendix 8: Notes from knowledge cafe**  
South Gloucestershire Care home learning network  
20 June 2012

This event was held over lunch, 12.00-1.00, immediately before a network meeting held at Woodlands Manor Care Home. There were five participants.

**Exercise 1**

Participants were given a page from a flip chart with four questions in 'H' formation (see appendix 1). They were asked to note their responses, individually, on post-it notes and attach these to the flip-chart. These were then discussed, with notes taken.

*What for you are the purposes of the network?*

- To keep knowledge skills up to date
- To keep abreast of new developments within the health and social care sector
- To ensure 'best practice' at all times
- Communication between homes
- Availability of up-to-date training in strategic areas, nutrition, dementia
- Sharing, caring, supporting
- Training, downloading
- Learning about new events and policies etc
- For us to de-stress knowing we are all in the same boat

*What are the things that make the network a success?*

- Sharing of best practice
- Realising you are 'not alone'
- Access to training opportunities
- Support of UWE providing continuity
- Home-led training sessions
- Joining together with staff from other care homes to share knowledge and concerns
- Unity empowers
- Free!!
- An opportunity to speak to staff from other homes
- To chat together about problems and solving techniques
- Sharing information
- Getting ideas
- Open atmosphere therefore ability to share sometimes difficult topics, without fear of retribution
- The support received throughout the group
- Meeting other colleagues and peers
- Being able to 'moan' without consequence
- Accessible to a wide variety of staff, eg cooks, cleaning staff
- Opportunity to share best practice

*What are the things that are not so good about the networks?*

- The general attendance is at times poor
- Getting more homes to commit to the networks
- Lack of attendance

- It is a shame and very sad that more staff don't take advantage of training offered which is free! I would have thought care homes could send one or two people

*What could be changed to improve the networks?*

- More emphasis on importance of attending
- ?certificate each session
- More awareness of how funding is found – may encourage people to take advantage
- Find a way of demonstrating the value of this training, often free training is de-valued, could perhaps charge if people don't attend

## **Exercise 2**

Participants were given a new page from the flip chart with another set of four questions. Again, they were asked to note their responses, individually, on post-it notes and attach these to the flip-chart. These were then discussed, with notes taken.

*What have you learned from coming to the Network?*

- Communication is key
- Greater understanding of dementia
- Support is valued. Sharing ideas is valued. Training handouts are appreciated
- A short break even on a 2 hour session is good
- MUST tool
- Nutrition and communication with residents with dementia
- MUST tool, hydration and nutrition, dementia

*What have you changed at work as a result of learning at the networks?*

- Fortifying foods with eg cream
- Now use the MUST tool for everyone. Formerly just used a weight and height chart
- Food fortification improved
- Approach to dementia care
- We now use the MUST tool – essential in the area of nutrition/weight
- Improved, clearer documentation of evidence

*What makes it difficult to share what you have learned?*

- Changing a culture needs passionate leaders. Some staff are reluctant to change
- Staff resistance to new practice
- Continuity

*What methods have you used to make sure others at work benefit from what you have learned?*

- Supervision sessions
- Staff meetings, team meetings, change-over, internal training, refresher / update sessions, staff supervision
- Noticeboard information, supervision sessions
- Staff meeting feedbacks
- Role model, coaching, de-briefing, one-to-one sessions
- Staff meetings, change-overs, PDPs
- Staff meetings

- Monitor and audit

Finally participants were given a fourth sheet of paper and again asked to record responses on post-its

*On a scale of 0-10, how important is it that the networks continue into the future? Why?*

10/10

Support for each other

Training as some providers are unable to afford external trainers

Staff deserve CHLN

10

We would really miss it. I don't believe we would work to such 'best practice' as we would be far more isolated. The support received is very important

10/10

Continued base to learn and develop skills. Support homes especially is small individual companies

10/10

Provides up-to-date knowledge

Informative and supportive

Appropriate training to need of care homes

10 out of 10

To share best practice

Develop training in various aspects with well informed and enlightened speakers

Supports small independent homes

To us it's a lifeline.

In previous job went to training provided by a large company provider and didn't benefit from it

'The involvement of UWE gives the programme some credibility. Tina knows everyone, who to contact as speakers. We don't know the most appropriate people'

## **Appendix 9: Action plan feedback Bristol**

### **Tissue viability and wound care**

We now throw away the things we do not use when we open a single use dressing, before we used to keep them

It is important to warm saline before cleaning a wound

We do not now use the heel pads: we have bought special pressure relieving boots for the residents

We went back and found that we have a folder regarding wound management which we have resurrected and updated

British formulary for care homes information is now available

We have set up a better communication between the trained staff and carers when a resident has a wound

## **Appendix 10: Action plan feedback South Gloucestershire**

### **Nutrition**

Importance of communication with kitchen staff – invited to handover and meetings

We are calculating BMI for residents as a guide

We discussed with the chef adding supplements to meals to increase calories

Now offer a variety of finger foods as snacks

Now use full fat milk for residents

Importance of food presentation – not too large portions as can be off-putting

Offering a choice rather than assuming what the resident wants

Need to re-assess residents' choices as they may have changed

## Appendix 11: Action plan feedback N Somerset

### Dementia Care

We have introduced the 5 word sentence and this has been really successful. Residents are able to follow instructions better which has led to reduction in their anxiety, they are able to compute what is being said.

For one resident, using a sentence approach has led to a happier resident and an improved relationship with the carer as they are also less stressed in trying to get the resident to understand

We have changed the way we present food and drink at meals. Residents now only have the cutlery they use at the time of needing it, rather than having all the cutlery on the table at the same time. We now offer them a drink when they are just finishing their main course; this has led to increased food and fluid intake as they need to concentrate on one thing at a time

We now pour the drink into a glass in front of the resident, so they can see what is being offered

We have done some work on life histories and memory boxes

We now use the 'This is me' booklets

We are in the process of adding names to the photographs that are in the residents' rooms so they become talking points

We have organised some training about the meaning behind the words that residents with dementia might say

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Centre for Health and Clinical Research  
School of Health and Life Sciences

University of the West of England, Bristol  
Glenside Campus  
Blackberry Hill, Stapleton  
Bristol BS16 1DD

**[www.uwe.ac.uk](http://www.uwe.ac.uk)**