Developing people for health and healthcare

A toolkit to set up narrative groups and education for front line care home staff

Developed from the Brent and Harrow CEPN for narrative multi-professional education in care homes

Health Education
North West London
About this Toolkit

This toolkit will help you to set up a community education programme for frontline care home staff.

The toolkit is divided into 6 sections:
1. The first section describes the background to the community education project
2. The second section offers advice and support with planning and evaluating your project
3. The third section gives some background to narrative groups and how they can support staff working in emotionally charged settings
4. The fourth section describes an education programme linked to the narrative groups that was developed in Phase 2 of the project.
5. The fifth section describes a narrative group for managers that was set up in Phase 2 of the project.
6. The sixth (and final) section is an appendix that lists places where you can get more information and help. This section also contains copies of documents used in the project that you can adapt to your own needs.

The main thing is that the toolkit is here to get you started on your community education programme for frontline care home staff.

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Whilst we endeavoured to provide accurate and up-to-date information in this Toolkit, we make no representations about the completeness, accuracy, reliability or suitability with respect to the content of this document. Any reliance you place on such information is therefore strictly at your own risk.
Innovative projects are most likely to take shape when local initiatives and national priorities align themselves together. This project was no exception.

National Priorities

In May 2013 the government published a document entitled: ‘Delivering high quality effective, compassionate care: Developing the right people with the right skills and the right values. A mandate from the government to Health Education England’.

The first page of this document refers to the terrible events at Mid-Staffordshire Foundation Trust, and the ensuing Francis Report into the catastrophic failures of care at that trust. In light of the Francis Report, key priorities in the May 2013 mandate to Health Education England included:

- Better support for patients and their families with long-term conditions such as dementia
- Improved integration of the health and care workforce
- Establishing minimum training standards for all Health Care Assistants

Community Drivers

At a meeting of Brent and Harrow GP educators, concern was expressed about the difficulty of providing effective training to staff working in residential care home settings, with a particular focus on reducing some of the homes’ high call out rates to London Ambulance Service.

Subsequently, the Lead Education and Training Board (LETB) invited requests for funding for pilot projects to expand educational provision into settings which typically had been overlooked in the past – including care homes.

In recognition of the ways in which taking part in narrative groups had been an essential part of their own GP training, a group of GP educators suggested that this provision should be extended to care home staff.

It was also recognised that although local GPs had on-going links with residential care homes within their practice areas, other agencies were also involved in healthcare provision including the local acute trusts, community pharmacists, London Ambulance Service, palliative care teams, and local hospices. A meeting with representatives from these groups was arranged so that their views on educational priorities for care home staff could be sought.

Priorities expressed by care home staff

In the initial meeting in each care home, care workers were asked about their own educational priorities. The following issues were raised:

- Dealing with challenging behaviour of residents (and sometimes, their relatives)
- Feeling better equipped to deal with End of Life Care
- Wound Care
- Reducing Falls

Care home managers were also asked about educational challenges for their staff and they mentioned:

- Lack of time during the day for training, and in some care homes, lack of appropriate physical space in which an educational meeting could take place
- High staff turnover
- Care home staff not accessing educational provision outside of the home
- Lack of visible career progression for care workers

In addition, managers also mentioned their own sense of isolation and lack of supervision for their own roles. (This was a major driver for piloting a narrative group for care home managers in Phase 2).

The next section describes how meetings were also sought with the relatives of residents in each of the care homes, in order to take relatives’ perspectives on board. In this way, the project from the outset recognised the importance of ‘Relationship Centred Care’. This is an approach advocated by My Home Life, an organisation that aims to improve the quality of care in care homes (See Appendix for contract details of My Home Life).

Relationship Centred Care focuses on developing positive relationships between older people, relatives and staff as this interdependence is seen as an important ingredient of providing high quality care. My Home Life point out that for relationships within a care home to be good, consideration must be given not only to the needs of individual older people who live and die in the home, but also to the needs of relatives who visit the home and the staff who work in the home.

The different steps taken in both phases of this project have attempted to keep the notion of Relationship Centred Care central to the work.
The Brent and Harrow CEPN Narratives in Care Home Education

Project Aims – Phase 1
Through an integration of the national priorities, the community drivers, the care home priorities and the Relationship Centred Care approach, the following aims for Phase 1 were identified:

1. Bringing together all the agencies involved in delivering acute care to care home residents, asking them to share experiences and to identify key topics for clinical education for staff in care homes.

2. Exploring the educational needs of care home workers (bands 1-4) through discussion with care home workers, their managers and residents’ relatives.

3. Introducing narrative reflective learning methods into four care homes in Brent and Harrow.

4. Synthesising project findings in order to provide education and Continuous Professional Development (CPD) for the wider workforce in order to improve their understanding of care home settings. This in turn should lead to better patient outcomes for residents and enhanced staff satisfaction of front line care workers.

5. Aligning our project with the national Health Education England (HEE) priority areas for dementia, band 1-4 staff and integration of care pathways and systems.

The link between Phases 1 and 2 is described more fully in the next section.

Section 2: Planning and Evaluation of your Project
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Phase 1: From September 2013 until June 2014

1. Engagement of NHS/Community Stakeholders

Two taster sessions on narrative groups were run by 3 GP Programme Directors, experienced in running narrative groups. The sessions were held at the Postgraduate Education Centre at the local Acute Trust. Representatives invited to this group included:

- Local GPs and GP trainees
- LAS Paramedics and trainees
- Community Pharmacists
- Local Age UK staff

With the exception of GP attendees most other attendees were not familiar with narrative group techniques. The two taster sessions received excellent feedback.

2. Approaching Care Homes

Four care homes were approached: 3 with particularly high LAS call out data, and one other, for the purposes of comparison.

The approach involved an initial phone call to the manager, followed up by an email summarising the project aims and a request to meet in person.

At the meeting the project leader covered the following issues:

- What the project involved and how it could benefit the care home
- Safeguards (specifically how one of the facilitators was a local GP with links to the home)

**Tip:** If the relatives’ meeting in a particular home tends to be a forum for complaints to be raised – the project leader should present the project at the start of the meeting so that the explanation of the project is separated from the later discussion of issues causing concern to relatives.

All 4 homes approached agreed to take part in the project. In addition, 74 other homes were sent leaflets about the project. Of these only 1 contacted the project leads to express any interest.

**Learning Point:** Leafleting alone will not draw care homes into the project. Face to face meetings are essential.

Phase 2: Session delivery in care homes

3. Agreeing Terms of Reference with the Care Homes

Terms of Reference were drawn up for each care home, to ensure that clinical concerns and safeguarding issues had been adequately addressed. (See the Appendix for copies of these forms).

Managers were interviewed prior to the first session in each care home in order to identify their own perspective on educational challenges facing the staff in their home.

Care also needed to be taken in choosing the best time of day for the sessions – i.e. at a time of day when care staff could be released safely from their duties, and significantly, when a room for the group to take place was available.

Homes agreed to host one ‘taster’ session and six further sessions. The taster session was facilitated by one of the project leads (an experienced group facilitator) in addition to the two facilitators assigned to that care home.

It was also agreed that staff members who attended at least 5 sessions would be given a Certificate of Attendance that they could include in their CPD portfolios.

4. Training the Narrative Group Facilitators

In addition to 4 GPs (each one of whom had a link with the care home to which they were assigned), 4 other facilitators were recruited from diverse professional backgrounds:

- 1 x occupational psychologist
- 1 x Primary Healthcare Assistant
- 1 x Age UK staff member
- 1 x Registered Mental Health Nurse

All facilitators were also required to attend 2 sessions of formal group supervision run by supervisors accredited by the UK Balint Society.

5. Holding the Narrative Group Sessions in the Care Homes

In order to build trust within the group as the narrative approach was new to all attendees, initial trust building exercises were found to be useful.

Written feedback was obtained from all participants after each session, whilst facilitators were required to complete reflective accounts following each session. Care home managers were also asked to complete a questionnaire following delivery of the final session (see Appendix).

6. Cascading education to the wider health and care workforce

The learning needs that underpinned these workshops were identified during Phase 1. Educational workshops using this information were delivered over the period of Phase 1 and Phase 2.

The following sessions were delivered in Phase 1:

a. An educational workshop on Advanced Care Planning organised in conjunction with a Palliative Care Darzi Fellow was delivered to 65 GPs and GP trainees.

b. A Grand Round on Advanced Care Planning was held at the local acute trust, with 45 attendees.

c. A meeting was held at the Postgraduate Education Centre of the local acute trust on the educational needs of care home staff. Attendees included GPs, dieticians and nurses.
The following learning events were delivered in Phase 2:

- Training End of Life Care Home Champions – a four day programme held at the local hospice attended by 16 staff from 8 homes
- Caring for Older Skin: Wound Care - a half day course for care home workers held at the local acute trust, and facilitated by the Tissue Viability Team
- Mental Health of the Elderly – facilitated by a RCN for the elderly
- Reducing Falls – facilitated by STARRS (a multi-disciplinary community team. See Useful Resources section for further details).

**Tip:** In order to deliver workshops that meet learning needs identified in the Narrative Groups, dates for the workshops should be set up to run at least 8 weeks after the end of the group sessions.

### Phase 2: August 2014 – March 2015

#### Original Plan

The original plan for Phase 2 was to duplicate Phase 1, cascading the narrative groups into other care homes.

Phase 2 also included the aim of delivering training in the 4 key areas (Wound Care; Managing Challenging Behaviour; End of Life Care and Reducing Falls) that had emerged as learning priorities in the Phase 1 narrative groups.

Phase 2 also aimed to create a managers’ narrative group.

#### Recruitment of Phase 2 Faculty for the narrative groups

10 multi-professional Fellows were recruited, building on links established in Phase 1.

The fellows came from the following professional backgrounds:

- 2 Paramedics (London Ambulance Service)
- 3 GPs (all had completed their GP training within the last years, ie were First 5 GPs)
- 1 Palliative Care Social Worker
- 1 Healthcare Assistant
- 1 Community Psychiatric Nurse
- 1 Occupational Psychologist
- 1 consultant in Old age Psychiatry

#### Adaptation of Phase 2

A number of obstacles were encountered recruiting new homes in Phase 2 including:

1. In homes undergoing changes in senior management or ownership, the priorities of the new managers/owners are directed towards embedding themselves in the home; getting involved in new projects is therefore not a priority.
2. Homes with new/transitioning management are particularly challenged to perform the logistical adaptations needed to release a group of staff at the same time.
3. Homes in a crisis situation (e.g. those who had recently had a poor CQC inspection), may also be experiencing high staff turnover. In this situation the logistics of changing rotas, plus the difficulty of releasing a group of staff at the same time can prove too challenging.
4. For smaller homes releasing 5-8 staff at the same time can be problematic.
5. Smaller homes may also struggle to provide a suitable meeting space for the groups to take place.

**Learning Point:** The Phase 1 model (i.e. where the groups were held within the home) favours larger homes with established management and low staff turnover. For other homes, the adapted Phase 2 model outlined below may be more appropriate.

Another difference between Phase 1 and Phase 2 recruitment was that in Phase 1 the project lead (a highly experienced GP) made initial contact with all of the homes. In Phase 2, the Fellows were tasked with recruiting the homes into the project.

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**Note:**

- d An educational half day for 30 GP trainees and 30 London Ambulance Service workers on the topic ‘Is it safe to leave my patient at home?’.
- e Inhaler training for 50 care home workers was delivered.
- f A presentation of the needs of care homes was delivered to a mixed group of 40 participants including GPs, CCG members, social care leads, mental health leads, senior nurse and clinician managers at the Brent CCG fair.
- g Mental Health of the Elderly – facilitated by a RCN for the elderly.
- h Caring for Older Skin: Pressure Care – a half day course for care home workers held at the local acute trust and facilitated by the Tissue Viability Team.
- i An educational half day was arranged for 30 GP trainees and 20 LAS workers on the topic of “Making the best decisions for and with our patients”. Faculty for the educational event included a consultant physician, an expert relative, a senior LAS trainer and Palliative Care consultant. The aim of the session was to empower GP and LAS staff to consider the autonomy of patients and the ethical issues (autonomy, beneficence) and clinical dilemmas faced in deciding whether to admit patients and relatives in the End of Life journey (old age, cardiac failure, advanced stage cancer and Dementia).
- j An educational half day for 30 GP trainees and 30 London Ambulance Service workers on the topic ‘Is it safe to leave my patient at home?’.
- k Caring for Older Skin: Wound Care - a half day course for care home workers held at the local acute trust, and facilitated by the Tissue Viability Team.
- l Mental Health of the Elderly – facilitated by a RCN for the elderly.
- m Reducing Falls – facilitated by STARRS (a multi-disciplinary community team. See Useful Resources section for further details).
Learning Point: The most senior person on the project should make initial contact with the care homes

As it became clear that many homes were struggling to release 8 members of the care team at the same time, an alternative model was used. Modelling the approach on the GP half day vocational training scheme (see section 4, page 20), each home was asked to send 2 care assistants to the sessions (i.e. releasing 2 rather than 8 members of staff at any one time).

Feedback from the care workers and management also indicated that 4 full day sessions rather than 8 half day sessions would be preferable.

All sessions were held at the postgraduate education centre at the local acute trust.

Budgeting

1 In recognition of the multi-professional nature of the project, and congruent with the approach advocated by Centre for the Advancement of Interprofessional Education (CAIPE -see Appendix, all group facilitators were paid the same fee irrespective of their professional background. This was set at standard half day rate used by Health Education North West London (HENWL).

2 Although this project was funded by HENWL, other potential sources of funding included:
   a The Local Authority (that has statutory responsibility for Care Homes in their area)
   b Clinical Commissioning Groups (who may be interested in the potential of the project to reduce unplanned admissions to acute trusts)
   c Skills for Health (See Section 6)
   d Third Sector charities such as Age UK or the Carer’s Trust (See Section 6)

3 All care home staff attending the narrative groups or educational sessions were paid for their time. In order to meet the costs of staff to cover colleagues attending educational sessions, the project paid each care home for the hire of a space within the home for the narrative groups to meet.

4 For the formal teaching sessions, if facilitators were attending as part of their standard day to day duties, they were not paid a teaching fee. If they were attending in their own time, they were paid the fee set by the local teaching providers.

Evaluation of the Project

A combination of questionnaires specially written for the project and standardised questionnaires were used. (see Appendix for copies of questionnaires used).

1. Questionnaires written for the project
   a Pre Project questionnaires for Care Home Staff
   b Pre Project questionnaires for Managers
   c After each session questionnaires for care home staff
   d End of project questionnaires for Managers

Standardised Questionnaires
   a The Maslach Burn Out Inventory
   b The Santa Clara Brief Compassion Scale