Nursing Midwifery and Allied Health Professions (NMAHP) Directorate

Phase 2 Impact Evaluation of the Care Home Education Facilitator (CHEF) Role

Executive Summary

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Context

Scotland's legislative direction for health and social care (Public Bodies (Joint Working) (Scotland) Act 2014) is based on the vision that by 2020 everyone will live longer, healthier lives at home or in a homely setting and that health and social care services will be integrated. This increasing focus on health and social care integration, coupled with progressively more complex care requirements for older people, makes the investment in education and workforce development in the care home sector a high priority.

The Chief Nursing Officer's Education Review, Setting the Direction (Scottish Government 2014) identified a range of successful strategies which currently enhance the quality pre-registration nursing programmes, and the student experience, in Scotland. The identification of these strategies, and their contribution to nursing healthcare education, reinforces that partnerships between the practice and education workforce can make a valid contribution to the development of a nursing workforce that is caring, compassionate and competent. These collaborations also help to assure the quality of the practice learning environment and support adherence to the standards set for Nursing and Midwifery Council approved programmes (Scottish Government 2014).

Despite this, it is acknowledged that practice learning environments are challenged to provide an increasing variety of experiences which will best prepare students and staff to practice within a changing health and social care context. This includes greater demand to access more diverse learning experiences in the community and with third sector and social care providers. The quality of these experiences must be assured if wishing to continue to provide positive experiences for pre-registration nursing students.

Since 2010, mentors in care homes have been supported by Care Home Education Facilitators (CHEFs). This support is designed to assist mentors in fulfilling their role of supporting the learning, teaching and assessment of pre-registration nursing students in the care home setting. CHEFs, through the sign-posting of educational resources and promotion of continuing professional development (CPD), also support mentors in care homes to act as role models for the delivery of safe effective, person-centred care. A key element of this involves CHEFs adopting the role of conduit in terms of national priorities, including the *Promoting Excellence* framework for caring for people with dementia (Scottish Government 2011).

Fourteen whole time equivalent (WTE) CHEFs were recruited between January and July 2010 by NES and 11 NHS Boards across Scotland. Although the role has evolved since its inception, the focus remains rooted in the support and development of practice education across the independent care home sector in Scotland. CHEFs, who are based in 11 NHS boards, work closely with NHS practice education facilitator (PEF) colleagues who are also responsible for practice education, but with a specific NHS remit.

A phase 1 service evaluation of the CHEF role was previously conducted and reported on during 2011/12. This evaluation underpinned the development of the role and also provided evidence to support continued Scottish Government funding of CHEF posts. This Phase 2 service evaluation was therefore designed to longitudinally evaluate the impact of the role (as delineated by the key role functions of the CHEF post) on practice learning support and development in the care home sector.

Evaluation Aim and Objectives

The overall aim of this project was to demonstrate the impact of the CHEF role. The evaluation objectives, outlined below, reflect the project aim, and were mapped to the key functions of the CHEF role (please refer to the full report to review these key role functions) to ensure fit and relevance in terms of the evaluation process:

1. Assess CHEF activity and its impact on the utilisation of care homes as practice learning environments
2. Evaluate the contribution of CHEFs in enhancing the quality of care homes as practice learning environments, including their support and development of mentors
3. Appraise the impact of CHEFs in developing care homes as contributors to the future nursing workforce
4. Identify and explore the implementation and effectiveness of partnership working relationships between Care Homes, NHS Boards & Higher Education Institutions (HEIs)
5. Identify and evaluate CHEF driven initiatives and the way in which they support and enhance staff development in care homes

Project Planning, Ethical Approval and Identifying Stakeholders

Project planning centred on the identification of an evaluation approach that would best consider impact. The Gerrish et al (2011) toolkit, originally designed to measure the impact of the nurse consultant role, was considered as an appropriate framework for the Phase 2 CHEF Evaluation. Although not developed with the CHEF role in mind, the impact evaluation principles highlighted as part of the Gerrish et al (2011) toolkit are arguably transferable when considering the key functions of the CHEF role and its subsequent impact.

Planning to measure impact required consideration of multiple stakeholders, most of whom have a vested interest in the role. It was considered important to collect discrete impact data in the first instance from each group as this would not only support discrete stakeholder group analysis, but would also allow for merging of data to generate collective stakeholder viewpoints of impact. Data collection methods identified as suitable for use following distribution of an initial scoping template included; focus groups and qualitative questionnaires. When designing the data collection tools all questions were mapped to CHEF key role functions. The structure and format of the questions reflected the model advocated by Gerrish et al (2011) in that questions centred on the retrieval of data relating to areas of direct and indirect impact.

The project plans were reviewed with reference to the National Research Ethics Service (NRES 2009) guidance documentation *Defining Research.* This helped to confirm the project status as that of service evaluation; NHS Ethic's approval was therefore not required. Despite this, and in light of the national status of the project, the West of Scotland Research Ethics Service (WOSRES) was asked to review the project plans and reaffirmed the project's service evaluation status. The project was logged with all 11 NHS Board Clinical Effectiveness departments. Opportunity for scrutiny of project documentation was also afforded to all HEIs invited to participate in the project, and any subsequent ethical approval recorded as part of project files. Stakeholder groups included; CHEFs, students, HEI academics, NHS Board Leads, Care Home Managers and mentors. Unfortunately however, despite a variety of attempts at recruitment, only 1 student agreed to take part in the project. Consequently, this data could not be used as it was not possible to protect the student's anonymity.

The Literature

As a means of informing this work, a rapid appraisal of literature, including policy and professional standards was undertaken, with a specific focus on the following aspects:

a) Policies and Standards: Caring for Older People and the Implementation and Management of Integrated Practice Learning in Care Homes
b) Potential influences on the delivery and quality of care in care homes
c) The care home environment as a practice learning experience and the attitude of student nurses to this environment and experience

To ensure contemporary care home practice and management was considered, the time span for the rapid appraisal was narrowed to include contemporary literature spanning 2006 – 2014. The search was further focused by narrowing the search parameters to retrieve English language texts only.

It became clear from the literature that the provision of care for older people is multi-faceted in terms of; the changing health and social care landscape; the increasing emphasis on the role of independent sector care; the ongoing development of independent sector staff and the provision of practice learning experiences for pre-registration student nurses in these areas. This combined with national and international recognition of an ageing population, and the challenges and opportunities which this presents, have already spurred moves towards a more integrated health and social care agenda. This in turn has initiated greater recognition of the need to develop shared learning, not only across the healthcare professions, but also across health and social care organisations, an aspect already highlighted as part of the care home education facilitator (CHEF) role.

The literature highlighted that learning and development opportunities in care homes include; opportunities to develop relationships with residents, patients and carers; opportunities to develop skills which are non-reliant on technology and also the provision of individualised holistic care in non-hospital environments.

In terms of caring for older people, there was evidence in the literature that attitudes towards caring for older people can, at times, be perceived as negative, perhaps reinforcing the importance of challenging negative stereotypes which may present. Working to ensure students' gain experience in environments which provide care for older people during their programme of study was however identified as a means of perhaps proactively changing these stereotypes. It has was also suggested by some authors that this experience can positively influence post registration career choices when considering future involvement in caring for older people. Although the benefits of theoretically preparing students for care home practice learning experiences are considered by some to be inconclusive, nursing's' professional regulatory body has adopted the stance of advocating the establishment of links between the young and the old can as one way to overcome prejudices which may exist.

Data Collection and Analysis

Gatekeeper access for each group was agreed in advance of commencing the consultation and data gathering process. Approaches to data collection included:

- A preliminary scoping template designed to generate statistical data indicative of the impact of the CHEF role
- Qualitative questionnaires and semi-structured interview/focus group guides to facilitate the gathering of data from which areas of key impact, from the perspective of each stakeholder group, could be garnered. These were developed with reference to CHEF key role functions, the rapid appraisal of the literature and the preliminary CHEF scoping template

A content analysis framework was adapted to support analysis of both qualitative and quantitative data across the stakeholder groups (please refer to Section 4 of the full project report to review this framework). Through triangulation of the data, key areas of CHEF role impact were; identified, statistically analysed and thematically categorised. In keeping with the content analysis method, coding, and counting of coding incidents in each of the thematic categories, supported the depiction of impact frequencies and patterns across stakeholder groups. These frequencies and patterns proved useful when attempting to rank impact in terms of the importance of the CHEF role and CHEF activity to each stakeholder group.

Findings

Four key impact themes emerged during qualitative data analysis. These are detailed as part of the table below, which also delineates the impact, in terms of response frequency, of each aspect of the CHEF role as reported by the stakeholder groups:

Key Impact Themes and Ranking of Response Frequencies

Ranking Key – Participant Responses Coded, Counted, Themed and Ranked (1 – 5) for Pattern Frequency.					
1 – Indicates Most Prevalent/Frequent Response					
5 – Least Prevalent/Frequent Response					
Stakeholder Group	**CHEFs**	**Care Home Mentors**	**Care Home Managers**	**NHS Board Leads**	**HEI Academics**
	Rank	**Rank**	**Rank**	**Rank**	**Rank**
CHEF Role – Key Impact Themes	**Rank indicates Qualitative Response Frequencies for each of the 4 Key Themes for each Stakeholder Group**				
KEY THEME 1 *Collaborative Working and Building Relationships*	**(2)**	**(2)**	**(2)**	**(1)**	**(2)**
KEY THEME 2 *Supporting Attainment of NMC Standards and the Delivery of Pre-Registration Nursing Education*	**(1)**	**(1)**	**(1)**	**(2)**	**(1)**
KEY THEME 3 *Sign-Posting Educational Resources and Supporting Continuing Professional Development*	**(3)**	**(4)**	**(3)**	**(3)**	**No Data Identified**
KEY THEME 4 *Enhancing Safe, Effective, Person-Centred Nursing Practice*	**(4)**	**(3)**	**(4)**	**(4)**	**(3)**
**Miscellaneous Data (not directly related to the CHEF role)*	**(5)**	**No Data Identified**			

Key Impact Theme 1 *– Collaborative Working and Building Relationships*

All stakeholders recognised the integral role of CHEFs in supporting the development of relationships and the implementation of collaborative working. In particular, collaborative approaches have been recognised as being fostered when implementing professional/regulatory requirements, including NMC (2008) *Standards to support learning and assessment in practice* and NMC (2010) *Raising and Escalating Concerns.* Stakeholders indicated that CHEFs, as a direct consequence of their specialised role remit, are better positioned to work across various groups and organisations and are also more able, as a consequence, to develop collaborative working relationships with these stakeholders.

Care Home Managers highlighted that CHEFs not only enhance communication, but also improve overall the perception of the care home environment externally. In addition, the relationships which CHEFs are able to build with care home mentors and managers positively impacts on the way care

home staff perceive the support which is available to them – and also the way in which they perceive their role as a care home employee, helping them to feel more valued in their role.

Communication across stakeholder groups was recognised as challenging at times and potentially reduced the ability of CHEFs to build relationships and foster collaborative working. Furthermore, analysis of the data suggests that there remains scope to reconsider how to further enhance current collaborative working strategies and how best to raise the profile of the CHEF role in terms of their support of health and social care integration.

Key Impact Theme 2 – *Supporting Attainment of NMC Standards and the Delivery of Pre-Registration Nursing Education*

Perhaps unsurprisingly, it emerged that mentorship and pre-registration nursing education are intrinsically linked. Stakeholders highlighted the impact of the role in key areas including; mentorship preparation and support; quality enhancement of the practice learning environment and student experience; instilling a sense of mentor competence and confidence and developing placement capacity.

Building mentor capacity in care homes emerged as an area requiring further development as a significant number of care homes were highlighted as having two or fewer mentors at the time of reporting. In light of the propensity for staff movement in this sector, this was recognised as presenting a risk of these areas becoming mentor free zones; a direct consequence of which would be a reduction in care home capacity to support pre-registration nursing students in practice. A similar situation presented when considering final placement capacity and sign-off mentor numbers.

The impact of the CHEF role in the dissemination and actioning of student feedback was confirmed as variable, with both managers and mentors reporting different experiences, and perceptions, of CHEF involvement and impact.

Key Impact Theme 3 *- Sign-Posting Educational Resources and Supporting Continuing Professional Development*

Sign-posting educational resources and supporting CPD for care home staff were confirmed as inter-dependent when delivering the CHEF role. CHEFs themselves expressed concern however that the full impact of their work was not always recognised as mechanisms to capture impact are not always in place.

Evidence of impact remained however including; enhancement of the quality of the practice learning environment, and the student experience, through the education and support of care home staff. It was also evident that work to support CPD in care homes helps to spawn collaborative working with other organisations including; the identification of training needs across the NHS and care home sector and the provision of fee-free education for care home staff in some HEIs.

Mentors reported incidences of active encouragement from CHEFs to continually professionally develop and care home managers are articulated the integral role played by the CHEFs in supporting newly qualified nurses in care homes to engage with Flying Start NHS®.

Key Impact Theme 4 *- Enhancing Safe, Effective Person-Centred Nursing Practice*

Although stakeholders commented with less frequency on the impact of the CHEF role in enhancing care delivery, it became that the CHEF role played an integral part. A review of stakeholder comments highlighted that stakeholder feedback often related to the practicalities of

CHEF interventions rather than the impact of these. This legitimised concerns expressed by CHEFs around the measurement of impact in terms of their role. This also highlighted that CHEF activity does take place which may well influence care delivery but is perhaps not clearly attributed to the CHEF role.

Despite this, there were examples of explicit CHEF role impact; in particular for one care home manager when relaying a sense of reassurance and confidence that their care home was now proactive and progressive as a consequence of CHEF input. Another also stated that supporting students, alongside access to the CHEF, led to staff development and an enhancement in the quality of care delivered. NHS Board leads also recognised the key role and contribution of CHEFs when citing collaborative policy development as an impact, and also when discussing CHEF input and support of health and social care educational integration and person centred practice. Perhaps more telling in terms of impact, is the concern expressed by one NHS Board Lead about the potential for fragmentation of practice learning in care homes should the CHEF role cease to exist.

Summary and Recommendations for the Future Delivery of the Care Home Education Facilitator Role

As the evaluation progressed, and findings began to emerge, continued fixed term funding for the role was confirmed by Scottish Government in January 2015.

Consultation with stakeholders served to highlight key areas of direct and indirect impact of the CHEF role, formulated as key impact findings in this report. In order to safeguard a future-based focus for the development of the CHEF role, these recommendations have been mapped to both CHEF key role functions and the strategic aims, categorised as *collaborating for the future,* in *Setting the Direction* (Scottish Government 2014); please refer to the full project report to view this mapping. These recommendations have also been developed with a view to both enhancing the strengths of the CHEF role and also further developing aspects of the CHEF role where impact is perhaps less evident:

1. **Recommendation 1 – Support CHEFs to both develop and implement impact measurement strategies.** This should include strategies and data which better define the contribution of CHEFs to the; enhancement of both care home staff CPD and their delivery of safe, effective, person-centred practice; enhancement of the quality of the student practice learning experience
2. **Recommendation 2 – Continue mentor capacity building, in particular targeting this CHEF activity with greater specificity.** This may involve targeting both care homes without mentors and also care homes where mentors numbers are reduced and there is a risk of these areas becoming mentor free zones
3. **Recommendation 3 – Continue to build placement capacity across the care home sector, including final placement capacity.** This should incorporate tripartite collaboration between; CHEFs, care home managers and HEI academics with responsibility for PLE allocation. This work should also consider the potential contribution that the availability of final placements in care homes can have on the recruitment of newly qualified nurses to this sector
4. **Recommendation 4 – Further develop multi-stakeholder collaborations which quality assure the PLE and the practice learning environment.** This should include a review of CHEF involvement in the delivery of annual updates, triennial review, educational audit, action planning and raising and escalating concerns
5. **Recommendation 5 – Define and implement clearer CHEF role parameters in terms of student PLE feedback.** This will help to ensure there is a clearer understanding of the CHEF role in the collation and dissemination of student feedback and their involvement in any subsequent interventions to enhance the quality of the practice learning environment/student experience
6. **Recommendation 6 – Review and refine the CHEF/PEF interface and collaboration parameters.** This work should consider both CHEF and PEF key role functions and priorities in light of the move towards a more integrated practice learning infrastructure in

Scotland. This should consider the discharge of both roles and the way in which the strengths of each can be retained to reduce the risk of increased emphasis on either role at the expense of the other

7. **Recommendation 7 – Define CHEF role and responsibilities for practice education as part of the health and social care integration agenda.** The findings from this evaluation would suggest that the CHEF health and social care integration education role is, for some stakeholders, unclear

References

Gerrish K, McDonnell A & Kennedy F, 2011. *Capturing Impact: A Practice Toolkit for Nurse Consultants* [online]. Available at: http://research.shu.ac.uk/hwb/ncimpact/NC%20Toolkit%20final.pdf. [Accessed 6th February 2015]

Public Bodies (Joint Working) (Scotland) Act 2014 [online]. Available at: http://www.legislation.gov.uk/asp/2014/9/contents/enacted [Accessed 21st January 2015]

National Research Ethics Service (NRES), 2009. *Defining Research* [online]. Available at; http://www.hra.nhs.uk/documents/2013/09/defining-research.pdf [Accessed 29th January 2014]

Nursing and Midwifery Council, 2010. *Raising Concerns: Guidance for Nurses and Midwives* [online]. Available at http://www.nmc-uk.org/documents/nmc-publications/nmc-raising-and-escalating-concerns.pdf

Nursing and Midwifery Council, 2008. *Standards to support learning and assessment in practice* [online]. Available at: http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Standards-to-support-learning-assessment.pdf [Accessed 20th March 2015]

Scottish Government, 2011. *Standards for the Care of Dementia in Scotland* [online]. Available at: http://www.scotland.gov.uk/Resource/Doc/350188/0117212.pdf [Accessed 6th February 2015]

Scottish Government, 2014. *Setting the Direction for Nursing and Midwifery Education in Scotland* [online]. Available at: http://dera.ioe.ac.uk/19343/1/00443655.pdf [Accessed 6th February 2015]

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