Care Home leadership: action is needed

Clive Bowman FRCP FFPH
Hon. visiting Professor bowmanclive@gmail.com

Julienne Meyer CBE PhD RN RNT
Professor of Nursing: Care for Older People; City, University of London
Executive Director: My Home Life programme

School of Health Sciences
City, University of London
Northampton Square
EC1V 0HB
London, United Kingdom

In England the 400,000+ care home beds shadow the entire NHS capacity of around 100,000 hospital beds. The growth of care home beds in the 1980's was largely fuelled by a lack of specialist housing and unsustainable local authority residential care facilities and closure of long stay hospitals. Today, care homes play an important role in caring for older people whose need for care is determined largely by dementia, other neurodegenerative disease, multi morbidity and frailty (1).

Of the 18,000 care homes in the UK; approximately 5000 only are registered for nursing, which means that most care homes rely on access to scarce community NHS services. For those care homes providing nursing, a combination of inadequate funding, unrealistic business planning and the challenge of securing staff (particularly Registered Nurses (RN)) has led to the increasing crisis in care particularly for publically funded older people with complex needs. Other compounding factors include a lack of clarity related to care home purpose, organisational structures, operational processes and intended outcomes and a lack of coherent leadership in both policy and practice. The wrongful use of high cost hospital beds to provide continuing care demonstrates that there is only one thing more expensive than proper strategic planning and organisation for an ageing society and that is not doing so!

The key business determinants for care home operators are occupancy, fee level and cost management and the greatest operational cost is staffing, in particular RNs. The importance and need for ready access to RNs is intuitively unarguable given the vulnerability of care home residents, but the current shortage of nurses in the community and care homes requires there should be clarity regarding how this scarce professional resource is to be used.

The modified Delphi process exercise reporting a set of competencies for RNs working in care homes in this journal (2) implies that they are not. Many of the care tasks determined can and are delivered by trained care workers routinely. Almost certainly it is professionalism that distinguishes the RN from

otherwise highly competent, care staff. RN's are subject to the Nursing and Midwifery (NMC) code of professional standards (3) and values set out in the Department of Health's Essence of Care (4). These are clear but general in nature not specialty specific.

RNs employed by care homes effectively define the difference between residential and nursing care facilities. Some care homes unable to recruit nurses or unsustainable agency fees are re-registering as residential facilities with increasing reliance on NHS community nursing support. A variety of NHS schemes are proliferating with clinical commissioning group nurses supporting care home beds. Additionally, NHS clinical commissioning groups having responsibility for determining eligibility for NHS funding of care typically use highly skilled RNs for this role. Whilst important for the management of public funds this doesn't actually contribute to the direct care and well-being of individuals.

Changes in policy focusing on ageing at home have led to older people entering care homes later, sicker and frailer. Further, many aspects of long-term care, e.g. dementia care, have been redefined as non-nursing work and are now delivered mainly by a social care workforce. Nowadays, as older people deteriorate, there is less movement from residential care into nursing homes. As a result, the similarities of older people in residential care to those in nursing care homes greatly outweigh the differences and arguably strengthen the case for RN input to all care home residents.

The role, deployment and funding arrangements for RNs in care homes should be properly established. We propose that there should be a lead nurse for older people in residential care undertaking regular assessments of need, primarily for the development and support of personalised care plans for care home staff to deliver and secondarily for purposes of reimbursement and case tracking. Linked to this should be education and support for care home staff to deliver the prescribed care. This role should be a clear NHS responsibility with greater clarity of ownership, governance and support. This would help define the NHS commitment to an individual's personalised health and social care plan. Such a development cannot be in isolation but requires competence-based accreditation of care staff to provide an assured delivery of these personalised care plans. Both nurses and care staff need a shared vision about what matters to older people that integrates evidence from both health and social care, with national approaches to personal care planning and clear competencies specified for delivery of these plans. The funding arrangements for the above need to be realistic and transparent.

Care home residents may be in a later phase of life, but they are not all actively dying and deserve expert approaches to their medical and nursing care needs (5). Frail older people in residential care do not neatly fit either into established paradigms of health or social care and are defining a new "space".

Unaligned competencies, developed in a context where wider systemic issues are not addressed, are unlikely to be transformative in themselves as illustrated by a number of initiatives that have failed to establish change. The National Service Framework for older people (6) prioritised assessment but no national process has been established. The introduction of the Liverpool Care Pathway from palliative care into care homes led to serious concerns and withdrawal following an independent review (7). Even the major drive of the National Dementia Strategy to control antipsychotic prescribing seems to have failed (8).

The conclusion must be that change requires much more commitment, whole systems thinking and aligned vision. Care homes and their residents need and deserve a coherent leadership responsible for well-developed central policies, programs, and systems to both ensure the best possible efficiency, consistency and development. The cost of establishing and maintaining this approach has the potential to bring to an end continued reinvention of wheels that seldom make a journey.

Key Points

- Care Home beds collectively are the largest single health and care provision in the UK.
- Staffing care homes is a continued challenge particularly with regard to Registered Nurses
- The current use of Registered Nurses in Care Homes is inconsistent, inadequately designed and unsustainable.
- Care Homes lack but need central leadership to realise safe, effective and efficient operational practices.

References

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