WORKFORCE CHALLENGE PARTNERS
Challenge to Change

Governance Framework for Workforce including the introduction of Nursing Associates, within X Care Home/s –

An example

May 2024

Developed in partnership with:

Anna Morgan MBE, RN, DipHE, BSc Hons, MA, RTT, ICF PCC
Independent Consultant & Coach

Contents

Governance Framework for Workforce including the introduction of Nursing Associates in X

1. Introduction

1.1 This document has been developed to provide assurance on workforce governance to support the RN, Carers and including the introduction of Nursing Associates (NA) as a substantial part of the workforce model for X Care Home with Nursing.

1.2 This sets out a governance framework for the clinical and care delivery. It will describe how the NA role has emerged, the responsibilities of the NA as part of the wider care team, the mitigation of any risks and the support and supervision provided to enable the NA to be established as a substantial role within the care team as part of a new emerging model within a social care setting.

1.3 The key purpose of clinical and care governance is to support staff in continuously improving the quality and safety of care. However, it will also ensure that wherever possible poor performance is identified and addressed. All health and social care professionals will remain accountable for their individual clinical and care decisions.

2. Background & Overview of X Care Home

2.1 X offers nursing and personal care on a short- or long-term basis, to meet the specific needs of residents who due to physical disabilities and illnesses requires assistance with personal care and/ or nursing care. X also cares for people living with dementia and require nursing care, and for people who require a period of convalescence following a hospital admission before they are able to return home. X also caters for those who are in the 45-65 age range and need help with personal care or require nursing care due to disabilities.

2.2 X can accommodate up to 52 residents. The mix of residents with nursing and non-nursing needs can vary at any time and the management of the dependency and care needs is considered on an ongoing basis between the Manager, Clinical Lead and the Registered Nurses (RNs) within the team.

3. Staffing

3.1 The introduction of the NA role has improved the recent recruitment and the retention of the existing RNs as they feel the skill-mix has enabled them to develop their role freeing up time to focus on more advanced nursing activities, more time for training and education of the care team and time for their own development. All of this is improving the quality and effectiveness of care for the residents.

3.2 As part of the current and future workforce model X has moved from a pure RN and Care Assistant staffing profile to a model that introduced the NA role as a substantial part of the care team working under the delegation and supervision of the nursing team to provide 24-hour continuity of care for residents.

3.4 The NA role is an accountable professional role enabling NAs to provide person centred care, making evidence-based decisions, solving problems and working within the limits of their competence. NAs provide compassionate, safe and effective care and support to people in a range of care settings. They monitor the condition and health needs of people within their care on a continual basis in partnership with people, families, and carers. They contribute to ongoing assessment and can recognise when it is necessary to refer to others for reassessment.

3.5 An NA contributes to the core work of nursing which frees up the time of a registered nurse so that they can work at the upper limits of their registration, focussing on more complex care needs and leadership. This role is only being used in England.

3.6 The NA role also offers the care sector a career pathway for experienced carers who wish to have a lifelong career in social care the opportunity to progress and be recognised for their skills and experience,

hence why X org has been inspirational in introducing this role into the business. This is a strong opportunity to offer people within X career progression pathways into care management and/or registered nursing.

3.7 In relation to the care team, X also employs Registered Mental Health Nurses, Care Assistants and Senior Care Assistants.

4. Workforce Strategy

4.1 Workforce and building a plan for the future is clearly in focus with strengthened leadership nationally and locally to help providers and commissioners navigate the challenging and complex territory we face due to chronic vacancies, age profile of the existing workforce and lack of strategy and planning over the last decade.

4.2 Within X ICS there is a Social Care Strategy and a local version of the People plan to guide partners on the ambition. NAs are the top priority role to grow and spread across all boundaries. There is a strong commitment that we will work with partners to explore new worker roles and teams that cross the boundaries of health and social care.

4.3 The People Plan has been refreshed and further underlines the commitment to NAs. In addition, the National NHS Long-Term Workforce Plan sets out the need to accelerate the expansion of the NA role across all sectors.

5. Standards of Proficiency for an NA

5.1 Since NAs were first introduced the Nursing & Midwifery Council (NMC) have issued clearer standards and guidance to support the growth of the role. The NMC standards of proficiency for an NA on registration are set out in Appendix 2.

5.2 On registration NAs will continue to extend their skills, through continuous education, training and with the development of local policies competencies can be expanded to meet the changing needs of patients/clients. NAs are assessed in four fields of care - adult, child, Mental Health and Learning Disabilities bringing a broader, more holistic approach to complement the existing workforce.

5.3 The table below gives an overview of the role of an NA in comparison to an RN, more information is included in Appendix 1&2.

Nursing associate 6 platforms	Registered nurse 7 platforms
Be an accountable professional	Be an accountable professional
Promoting health and preventing ill health	Promoting health and preventing ill health
Provide and monitor care	Provide and evaluate care
Working in teams	Leading and managing nursing care and working in teams
Improving safety and quality of care	Improving safety and quality of care
Contributing to integrated care	Coordinating care
	Assessing needs and planning care

6. Leadership

6.1 The leadership and management of X and the care team is the responsibility of the Registered Home Manager. At X there is a Clinical Lead who works in partnership with the Home Manager. Clinical leadership is provided by the RN team in partnership with the management. X also has an Operational Manager as part of the leadership team.

6.2 NAs and Senior Care Assistants are also part of the extended leadership team, developed and supported by RNs and the management team.

7. Systems & Processes to support Quality of Care – This section describes the systems and processes in place to support the workforce model to providing care to the residents in this care home environment.

7.1 X Care Home Staffing Model

7.1.1 There is a 3-shift system, Morning shift is 0800-1400, Afternoon shift is 1400-2000, and the Night shift is 2000-0800. There is a robust handover for the care team at the beginning of each shift (15 mins at commencement of a shift) where important information on the residents' conditions and any other issues can be discussed, including activities for the smooth running of the next shift such as break times, additional duties required. This is documented.

7.1.2 The rotas are prepared 4 weeks in advance.

7.1.3 Staffing consists of first level Registered Nurses, Nursing Associates (NAs), Senior Care Assistants and Care Assistants.

7.1.4 NAs are a valuable part of the current and future skill mix at X as this role is vital to the development of the staffing model and nursing team. The role is registered with the NMC with clear standards of proficiency and will take charge of shifts as part of the rota once successfully through preceptorship and induction.

7.1.5 The RNs will continue to work in partnership with the home manager to assess the nursing needs of any nursing residents and the RNs will be responsible for the development of the care plans and on-going evaluation of care. This will inform the continuous deployment of the care team as an important part of rota planning.

7.1.6 Where an NA is in charge of a shift without an RN being on site, an RN will be available on call throughout the period.

7.1.7 An RN will also be scheduled on shift within a maximum of 24 hours of an NA taking charge. This will be reviewed for effectiveness as part of the regular staffing audits performed by the management team.

7.1.8 An example of staffing levels is illustrated below:

Seven day – morning & afternoon rota:

Based on current occupancy of 23 residents (5/1/24)

- 1 RN or NA, 2 Senior Care Workers, and 4-5 Care Assistants
- As the occupancy increases the number of Care Assistants will increase and RN/NA hours as per needs of the residents

Night Rota:

- 1 RN/RMN is on duty at night 7 nights per week, in addition, 3 care workers are on the night rota

7.2 Dependency

7.2. 1 Although X is registered to provide nursing, there is no statutory requirement to have 24/7 RGN or RMN cover. The regulations require X to have sufficient numbers of staff with the appropriate training and experience to meet the needs of residents.

7.2.2 The Registered manager will in partnership with the RNs determine the appropriate skill mix at any one time (guided by the model above). The exact number of nursing and non-nursing staff on duty at any time will vary to meet the dependency needs of the residents being cared for in the home.

7.3 Supervision of RNs, NAs and Care Staff

7.3.1 Supervision is provided to all staff. A Clinical Lead will provide supervision to the RNs and Senior Care Staff who in turn will supervise the Care Assistants. The NA/s and Carers have monthly regular supervision of the caseload and ad hoc supervision whenever it is needed.

7.3.2 The NAs and Carers have access to support at all times 24/7 through the on-call rota.

7.3.3 The on-call policy requires the on-call individual to respond immediately to the call and to make decisions on whether a face time call is needed or a physical visit from an RN or management if they are off site.

7.3.4 The on-call rota is planned and available at least 4-6 weeks in advance with named individuals.

7.3.5 The NAs and Carers are able to contact senior staff when off-site using the escalation & on-call process (Appendix 4).

7.3.6 Supervision to the senior clinical and non-clinical staff is provided from an external company.

7.4 Training & Education

7.4.1 Both the RNs and the NAs have responsibilities in providing regular training and education to the wider care team at X as part of the ethos at X. All staff are offered on-line training through social care TV, NVQ and Care Certificate are offered alongside advanced training through the champions roles and other areas of interest.

7.4.2 Following successful registration and completion of their NA training, the NAs receive regular training and education on the specific needs of the residents. For example, if X has residents receiving Continuing Health Care who require Hickman line care and regular bloods. The training and sign-off competencies are provided by the local Acute Hospitals to enable the RN/NAs to provide this care. On-going competency assessment for these skills is provided by the RNs in partnership with other members of the wider multi professional team within the ICS.

7.4.3 The leadership team are working with the NA to develop a robust continuing professional development plan to increase their competencies over the next 2 years, this is then recorded in their annual appraisal. This will also enable NA/s to be able to provide support for students in partnership with the RNs, and it is hoped that practice placements will be able to be offered in the future to enable students to embrace learning within X to educate the future nursing workforce about the importance of care for people within the social care sector.

7.4.4 The National Preceptorship Framework launched in Sept 22 sets out the standards for all newly qualified NAs are supported to access a robust period of preceptorship as this plays a key role in retention, allowing them to translate their knowledge into everyday practice, grow in confidence and have the best possible start in their careers.

7.4.5 Additionally, the preceptorship website for health and social care professionals is available and has been updated: NHSE/I National preceptorship programme 2022 (tavistockandportman.nhs.uk)

7.5 Risk Assessment & Mitigation

7.5.1 In order to support the evolving NA role within X, a risk assessment has been completed with mitigation in place to ensure residents safety and support to the NAs is maintained when RNs are not in attendance on shift. The NA is accountable for their action and omissions, with clear standards and a code of conduct, therefore the risks are fully mitigated and low. See Appendix 2.

7.5.2 Three main risks have been identified in relation to NAs/Senior Carers taking charge of a shift with no RN on site as described in Appendix 3. With mitigation the risks are low.

7.6 Escalation Process & On-Call Arrangements (Appendix 4)

7.6.1 If there are any incidents, and/or complaints raised by staff, residents, relatives or other professionals directly with the NA then the policy for complaints and incidents is followed with documentation and reporting to the manager and RN as required. There is an in hours and out of hours process in place.

7.6.2 The RNs are part of an on-call clinical rota to ensure that additional support is provided to the care and management team in and out of hours.

7.6.3 Should an NA need clinical advice the on-call process is followed. The RN is able to speak directly to the NA and use face-time function if there is a need to observe an interaction or query.

7.7 Care Planning & Documentation

7.7.1 All residents have care plans in place and NAs and Carers follow the home policy for the completion of documentation.

7.7.2 The NA 10 standards for Proficiency (Appendix 1) underpin the care planning process and risk assessment requirements for all residents at the point of registration, this will be developed further through competency and policy to support patient/client needs.

7.8 Management of Incidents

7.8.1 All NAs and Carers are trained to follow the X management of Incidents policy.

7.9 Resident Experience

7.9.1 The aim of this role is to ensure the best possible care and treatment experience for service users and families by providing continuity and advancing the skills of the X care team. The NA role is a good example of this. Regular satisfaction audits are carried out making residents and families aware of this new role.

7.10 Effectiveness of Care and the NA role

7.10.1 The effectiveness of care is ultimately delivered by robust care planning and evaluation of care in partnership with residents, their families and the whole care team. The NA/s are making a significant contribution to the quality of care to the X residents. The evaluation of this care is measured by regular satisfaction surveys, compliments, complaints and review of incidents as well as adhering to the following standards:

- NAs practice in accordance with their professional accountability, NMC professional standards, codes of conduct and the organisational values
- NAs are responsible for upholding professional and ethical standards in their practice and for continuous development and learning that is applied to the benefit of the residents

- NAs provide accurate information on quality of care and highlight areas of concern and risk as required
- NAs work in partnership with management, service users and carers and other key stakeholders in the designing, monitoring and improvement of the quality of care and services.
- NAs will speak up when they see practice that endangers the safety of service users in line with local whistle-blowing policy and regulatory requirements
- NAs will engage with colleagues, service users, and partners such as primary care and social care to ensure that local needs and expectations for safe and high-quality health and care services, improved wellbeing and wider outcomes are being met.
- NAs adhere to the code of conduct by Prioritising People, Practising Effectively, Preserving Safety, and Promoting Professionalism and Trust

8. Conclusion

8.1 X are committed to the delivery high quality care to their residents and in doing so have developed an innovative approach to strengthening the staffing model by growing their own Senior Care Assistants and NAs from their own care team as well as successfully recruiting into X.

8.2 The NA role provides an excellent addition to the care team supporting the RNs and Carers in developing a significant career pathway for other care staff. The continuity, quality of care and experience for X residents are central to the development of the workforce model.

9. Review

9.1 This framework will be reviewed every six months for the first year and then frequency will be determined following review outcomes and any CQC inspections.

Appendix 1 Additional Evidence Base for changing the skill-mix

In an interview with the Nursing Times in February 22, Martin Green, the Chief Executive of Care England stated that "Recruiting and retaining nurses remains one of the biggest challenges facing the care sector". Social care chief interviewed on nursing challenges in sector | Nursing Times Feb 22. According to Professor Green, there are around 145,000 vacancies across the sector in England. Separately, data published in October 2021 showed that the number of registered nurses in adult social care in England is down by almost 17,000 (33%) jobs since 2012. (Skills for Care – see below)
Registered nurses (skillsforcare.org.uk) October 2021.

Key findings in the report show that:

- There were 34,000 registered nurses working in adult social care in 2020/21.
- The number of registered nurses has continued to decrease, down 1,800 jobs (5%) between 2019/20 and 2020/21.
- Registered nurses were one of the only jobs in adult social care to see a significant decrease over the period (down 16,900 jobs, or 33% since 2012/13). The number of registered nurse jobs decreased year-on-year between 2012/13 and 2019/20 (from 51,000 to 34,000).
- The recruitment and retention of this group is under significant pressure, which has led to the inclusion of nurses on the Migration Advisory Committee's shortage occupation list in 2015 and have remained listed ever since.
- Around two in five registered nurses (38.2%) were estimated to have left their role within the past 12 months, this was approximately 11,000 leavers.
- There was an estimated vacancy rate of 9.9% equivalent to around 3,200 vacancies at any given time.
- Registered nurses in adult social care had a much higher turnover rate (38.2%) than their counterparts in NHS[1] (8.8% for registered nurses and health visitors).
- Around 15% were on zero-hours contracts, down from 18% in 2012/13.
- Around 64% were British, 16% had an EU nationality and 20% had a non-EU nationality.
- Registered nurses were paid a mean annual salary of £33,600 in the independent sector.
- This average was slightly higher than NHS Band 5 (£25,655 to £31,534) at which newly qualified nurses start in the NHS, but lower than most of NHS Band 6 (£32,306 to £39,027).

What's your problem, social care? | The King's Fund (kingsfund.org.uk) Dec 2019

Better basic pay – Increasing basic pay is vital, and pay differentials between junior and senior staff need to widen. This is difficult to achieve uniformly though because care workers are employed by around 20,000 independent organisations and, unlike the NHS, don't have national pay rates. Nor can all these providers afford to pay more, since the fees they receive from local authorities have been held down. The workforce employed by adult social services departments, England 2021 (skillsforcare.org.uk) p17. When analysing the 'other' employment status further (which includes 'Bank or pool', 'Agency' and 'Other' workers), Direct care roles had the highest proportion of bank or pool workers (7%) and the professional group had the highest number of agency staff (8%).

Nursing associates (skillsforcare.org.uk)
An employer's guide to the deployment of qualified registered nursing associates in social care settings (skillsforcare.org.uk)
Kessler_et_al_2022_Nursing_Associate_role_in_Social_Care.pdf April 2022. Three main narratives emerged, related to: the labour market, care quality and the business case.
#WeCareTogetherPeoplePlan – page 29, file.html (norfolkandwaveneypartnership.org.uk)
Standards of proficiency for registered nursing associates - The Nursing and Midwifery Council (nmc.org.uk) and nursing-associates-proficiency-standards.pdf (nmc.org.uk)
Workforce planning and deployment of nursing associates | Health Education England (hee.nhs.uk)
The Code (nmc.org.uk)
Briefing for providers: Nursing Associates (cqc.org.uk)

Appendix 2 NMC Standards of Proficiency for Nursing Associates at the point of Registration

The standards of proficiency represent the standards of knowledge and skills that a nursing associate will need to meet in order to be considered by the NMC as capable of safe and effective nursing associate practice. These standards have been designed to apply across all health and care settings.

Nursing associates provide care for people of all ages and from different backgrounds, cultures and beliefs. They provide care for people who have mental, physical, cognitive and behavioural care needs, those living with dementia, the elderly and for people at the end of their life. They must be able to care for people in their own home, in the community or hospital or in any health care settings where their needs are supported and managed. They work in the context of continual change, challenging environments, different models of care delivery, shifting demographics, innovation and rapidly evolving technologies. Increasing integration of health and social care services will require nursing associates to play a proactive role in multidisciplinary teams.

The proficiencies have been designed to align with the latest standards of proficiency for nurses:

- To allow people to understand the differences between the two roles
- To enable education providers to facilitate educational progression from nursing associate to nurse
- To demonstrate how the nursing associate role can support the registered nurse, to allow registered nurses to deliver the NMC's enhanced 'Future Nurse' standards of proficiency.

The outcome statements for each platform have been designed to apply across all health and care settings. At the point of registration, nursing associates are required to meet all outcome statements and to demonstrate an awareness of how requirements vary across different health and care settings. As the nursing associate role is generic, students may demonstrate proficiencies in any appropriate context, and there is no expectation that they must be demonstrated in every health and care setting.

Platform 1: Being an accountable professional
Platform 2: Promoting health and preventing ill health
Platform 3: Provide & monitor care
Platform 4: Working in teams
Platform 5: Improving safety and quality of care
Platform 6: Contributing to integrated care
Annexe A: Communication & relationship management skills
Annexe B: Procedures

For the full standards: nursing-associates-proficiency-standards.pdf (nmc.org.uk)

Appendix 3 Risk Assessment – NAs/Senior Carers in charge of a shift without RN on site

Risk 1: <u>If a resident requires complex nursing care when an RN is not physically present at X then there is a risk that quality of care is compromised.</u>

Likelihood and consequence: 2x3=6 (Moderate) The likelihood of this risk is possible, with reportable injury and moderate damage to reputation.

Mitigation

1. All residents have been assessed by an RN on admission and regularly thereafter, and care plans and risk assessments have been signed by an RN and are reviewed monthly and/or on condition change.
2. All needs are planned for and anticipated; care is delegated to NAs within their scope of practice and competency.
3. NAs/Senior Carers are able to contact the on-call RN for advice with an immediate response, via a mobile phone and described in the on-call policy and escalation framework.
4. NAs/Senior Carers are able to call emergency services in an emergency situation.

Mitigated Risk Score: 1x3=3 (Low) Through the above mitigation the likelihood has reduced to extremely unlikely and the risk of reportable injury and damage to reputation if an adverse event occurs remains the same.

Risk 2: <u>If a clinical incident occurs when an NA/Senior Carer is in charge of a shift without an RN in the building then there is a risk that it may not be managed comprehensively.</u>

Likelihood and consequence: 2x3=6 (Moderate Risk) The likelihood of an incident happening is a remote possibility with a consequence of a reportable injury.

Mitigation:

1. NAs/Senior Carers are trained in managing the deterioration of residents, managing risks such as pressure area care and supervising carers.
2. NAs/Senior Carers are trained in incident management and understand how to complete an incident process including using escalation and reporting processes.

Mitigated Risk Score: 1x3=3 (Low) The likelihood of an incident not being managed has reduced, and the severity remains the same.

Risk 3: <u>If an NA/Senior Carer makes a medication error in the absence of an RN being present in the building, then there is a risk that a resident may suffer harm.</u>

Likelihood and consequence: 2x3=6 (Moderate Risk)

Mitigation:

1. Medicines management including administration is within the training, education, preceptorship and standards of proficiency of an NA role.
2. Senior Carers have specific resident focused medicines management training.
3. NAs/Senior Carers follow a care plan and treatment chart set out for each resident.
4. Handover is attended at every shift to discuss residents' status, and NAs/Senior Carers know their residents well.
5. Additional training for specific residents is given to all NAs/Senior Carers and signed off by an RN as the need arises.
6. NAs/Senior Carers are trained in incident reporting and escalation of medication errors as part of their role.

Mitigated Risk Score: 1x3=3 (Low) The likelihood of a medication error happening has reduced and the risk of injury after mitigation remains the same.

Appendix 4 Escalation & On-Call Process

Person in charge of shift

- **Adverse incident occurs, and/or**
- **Resident's condition deteriorates (known end of life or suspected sepsis), and/or**
- **Advice is needed regarding medication or use of bespoke equipment (such as pressure relieving device)**
- **Staffing issue has arisen e.g., sickness, conduct**
- **Other concern or query**

↓

1. Person in charge of shift contacts On-Call and carries out a phone call or facetime communication to discuss concern

2. On-Call considers the need for face-to-face visit if required

3. Person in charge of shift informs manager and/or operational manager of issue – if within 9-5 hours, incident is recorded and discussed with Manager at the earliest point

4. On-Call manager function can be used for out of hours issues if required and agreed through discussion with person in charge of shift

↓

On-Call 24/7 Contacts and numbers (see Rota)

↓

1. On-Call person documents date, time, query and advice given

2. Person using on-call documents action taken in residents records as required and in the handover procedure

3. Manager/RN follows up issue at the next shift and updates all records accordingly

↓

Other Emergency Contact details