

Title of Thesis:

**Evaluating the extent of a learning environment and its
impact on standards in care homes: *the case of Nightingale
Hammerson (NH) nursing home in UK.***

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DECLARATION

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STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Where correction services have been used the extent and nature of the correction is clearly marked in a footnote(s). Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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Abstract

The overarching aim of this research was to evaluate the extent of a learning environment on standards in a care home through the case study of Nightingale Hammerson (NH), which is the first Care Home Education Centre (CHEC) in Europe. Having worked for NH care from 2010 till 2020 as director of care services, I have then been drawn into the topic of how to improve poor standards of care in the UK. Furthermore, developed an interest to explore how this can be achieved through a learning environment. This research, therefore, attempted not only to assess how a learning environment could create an impact across the care industry but also identifies the challenges that have affected the standards of care as 21% of care homes in the UK are rated either as requiring improvements or inadequate by Care Quality Commission (CQC).

To understand and assess the learning practices at NH, a qualitative research methodology is adopted and relevant empirical evidence is collected from 30 stakeholders including educators, managers, directors and trustees. Primary evidence revealed a shift from the current industry practice of staff training to learning through an empowerment model as part of NH's Care Home Education Centre (CHEC). Which resulted in improved standards of care based on CQC rating of "Good" in 2016 to Outstanding" from 2018 till now. Secondary evidence further elaborates how NH's CHEC learning environment was designed to deliver accredited and informal education to their workforce. It highlights how a Continuous Practice Development Process (CPD) linked to knowledge, skills, competencies and Key Performance Indicators (KPI) for each staff group made a difference to the performance and standards within the home.

My recommendations to the care home industry are to adopt learning environment principles by standardising education, utilising qualified educators and assessors. Additionally, to develop leadership and governance skills that can transform practice from a culture of compliance to learning through coaching, mentorship, research and student placements. I recommend CQC changes its approach on inspections to focus on CPD education and not only provider's compliance in mandatory training. My research limitations are associated with a lack of literature around learning environments in care homes and the unknown future impact of COVID-19. However, there are opportunities for further research to compare transformational changes in this case study against another care home that develops a learning environment.

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List of Abbreviations

AET	Adult Education Training
CHEC	Care Home Education Centre
CPD	Continuous practice development
CPR	Cardiopulmonary resuscitation
CQC	Care Quality Commission
CREDIT	Compassion, respect, excellence, dignity, integrity and teamwork
DBA	Doctorate of Business Administration
EoLC	End-of-life care
GSF	Gold Standard Framework
HCA	Health care assistant
HR	Human resources
H&S Act	<i>Health and Social Care Act 2008</i>
IQA	Internal quality assurer
IT	Information technology
JMT	Junior Managers Team
KLOE	Key line of enquiry
KPI	Key performance indicator
MDT	Multi - Disciplinary Team
NH	Nightingale Hammerson
NHS	National Health Service
NMC	Nursing and Midwifery Council
NSASC	National Skills Academy for Social Care
NoCHR	Network of Care Home Researchers
NVQ	National Vocational Qualification
ONS	Office of National Statistics
PCC	Person-centred care
QCF	Qualifications and Credit Framework
RCC	Relationship-centred care
SHCW	Senior health care worker
SMT	Senior Management Team
SOFI	Soft Observation Framework for Inspection
UTI	Urinary tract infection
UWTSD	University of Wales Trinity and Saint David

Chapter 1: Introduction and Research Aims

This research aims to evaluate the extent of learning and its impact using Nightingale Hammerson (NH) nursing home as a case study. The research intends to assess the changes in standards at NH when they introduced a learning environment in 2016. To which NH was recognised to be one of the “Outstanding” care homes in the UK by 2018. I therefore consider that if this is the case, this research will seek to assess the critical success factors which led to the recognition of this outstanding award. The research will analyse and understand specifically how NH managed to transform learning through the Empowerment model they created which has also made them the first Care Home Education Centre. Furthermore, whether this learning environment if proven to be effective can be replicated across the industry to change the care standards. Thus, this first chapter provides a brief introduction to the study and the context, in terms of the research site in NH whilst considering their current learning practices in comparison to the wider industry. It also examines the problem situation, leading to a formulation of the research questions that the study attempts to address.

Chapter 2 explores literature to establish what is known concerning learning environments within the care home industry. It also highlights the challenges in finding evidence to support the evaluation of a learning environment and standards of care within the industry. Therefore Chapter 2 starts by defining what “learning” is all about and the importance of learning within the industry. It further explores the policies and procedures that are in place to support learning and analyses what is known to be the impact on learners and stakeholders within the industry.

The research design described in chapter 3 is based on the case study method and describes in detail how the data were collected during the primary and secondary stages at NH in the UK. The rationale & the justification for this choice of methodology over other relevant methods is explained and how storytelling as an epistemology is selected to report findings and chapter three also explains this choice. This chapter further highlights ethical issues and how they were addressed.

Chapter 4 presented the empirical evidence collected via primary & secondary sources concerning the learning practices at Nightingale Hammerson (NH), and the way the various stakeholders use and relate to them. The findings are organised in terms of stakeholder group questions, describing the views of the various stakeholders associated with NH. The findings

in this chapter, therefore, describe how the role and extent of creating a learning environment at NH were perceived by the main stakeholders and provide appropriate examples.

Data presented in chapter 4 are then interpreted and analysed in Chapter 5 through a qualitative methodology and by referring to the stakeholders on what has been learned about the learning environment at NH. This chapter also addresses the original research questions posed, as well as examining the findings using the learning environment through their empowerment care model. In Chapter 6, I am able to draw some general conclusions, outlines the academic, methodological and practical contributions as well as limitations of the research and makes recommendations for further research.

1.1 History of Learning and Training at Nightingale Hammerson (NH)

My experience of working in the organisation for 10 years made it the top choice for the case study as it is also the largest single-site care home in the UK. Whilst most care homes have an average bed capacity of about 70 beds, NH has a capacity for 215 senior residents. The average age of admission is 92 years, and 10% of residents are aged over 100 years. The organisation provides residential, dementia, nursing and palliative care, which covers all types of care within the industry. However between 2014 and 2016 various complaints started to emerge as main stakeholders i.e. residents and relatives raised concerns about the level of service they were receiving, and their expectations not being met. Incidents reports viewed at NH indicates that some of the complaints were of a serious nature. These complaints resulted in safeguarding concerns that were reported to the local authority for investigation. Human resource records for that same period shows that NH's turnover of up to 35% within the care team of 300 staff, against the industry average of 25% in the same period. Consequently, staff started to leave and the organisation struggled to fill up vacancies. The organisation had staff vacancies in critical posts such as nurses and struggled to recruit new staff because of industry-wide nurse shortages and negative publicity about poor standards in the care home industry as a whole. This resulted in increased use of temporary and agency staff who only came to cover shifts and had no commitment to the values and standards of the organisation and required induction at every shift into how NH operated.

Over the same period, NH had been following the industry compliance practice of only providing the mandatory training outlined in Figure 1.1. Whilst expected industry compliance targets for each mandatory training was 100%, due to high turnover NH only achieved at most

60%. They struggled to keep up with the required staff induction training which often meant that in some cases new staff would complete training months after commencing work. The outcome of this was a team of newly employed staff end up working with Agency and part temporary staff that did not have the same training. This is created huge skills and competency challenges in delivering high standards of care, hence the complaints and safeguarding issues the organisation continuously had to deal with.

The research identified that all of NH's training was outsourced via different training providers delivering classroom-type sessions. Once a member of staff had attended a session, they were considered compliant with training and only needed to attend a refresher session within the next 12 months. In line with industry practice, NH did not have a system to link training to competencies or assess how the practice changed following the sessions provided. There was no quality assurance system to scrutinise or evaluate the training provided against trends in practice concerns. Although there was always a training budget allocated, most trainings happened during working hours and, for night staff—after their shift—which meant they were always tired, making it impossible to attend or concentrate.

1.2 The Impact of Learning at NH

During the time I have been working in the organisation, it was noted that following changes in leadership in 2014, the organisation transformed its training strategy. Two years later, when NH had improved CQC inspection results as their rating became overall 'good', furthermore after its 2018 inspection it received an 'outstanding' rating. According to CQC 2019 star ratings published on their website, over those four years, NH was one of only 3% of care homes in the UK to demonstrate that outstanding level of standards of care (CQC, 2019).

Therefore NH's improvement and sustainability in outstanding standards of care to date makes it a suitable case study for this research. Especially considering that industry trends during that same period indicated that 15–20% of care homes that were rated 'good' got downgraded at their next inspection. This was due to inconsistency in maintaining those standards. The approach and model NH took is to become a Care Home Education Centre (CHEC) through the introduction of learning both formal and informal within the workplace, facilitated by educators, assessors and supervisors which empowered staff to learn through practice. This approach created a learning environment that has changed the way education and care are delivered in the home as part of their workforce empowerment model. Evaluating the

significance of this approach could provide a model for other care homes to follow, and improve the current situation of poor standards of care in the industry.

1.3 Problematising Learning in the Industry

The biggest problem which the industry faces is that there is no clear definition of learning and or a learning environment specific to the industry requirements and standards of care for current and future needs. Therefore no examples of how learning in a care home environment could be designed in order to provide the best experience and outcomes in relation to improved standards of care. This is compounded by the lack of research in the subject which means the current industry practice of compliance driven training is continued as the only standard practice in which the whole industry relies on to provide information to staff.

Current learning within the care home industry is defined by the CQC fundamental standards underpinned by the Health and Social Care Act 2008 (hereinafter ‘the H&S Act’). Standard 18 of that act states that employers should ensure that staff is adequately trained and supported to develop skills and competencies relevant to the care needs of the residents within their care. The regulation further outlines that providers should evidence supervision and appraisals to ensure that staff is capable of continuing working and meeting the roles and responsibilities they are assigned. There are 8 mandatory training courses that each employer is required to provide, at the very least (see Figure 1.1).

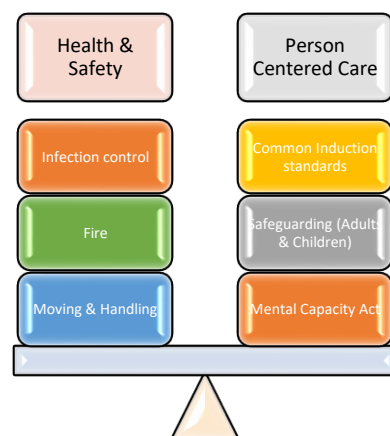


Figure 1.1: H&S Act mandatory courses Source: created by Author (2019)

Neither the H&S Act nor the Care Quality Commission defines how these training sessions should be delivered. There are no clear guidelines about standardised training objectives,

outcomes, competencies or evaluation of training. The training refresher frequency is left to employers to determine based on their self-assessment of needs. Although most providers take an annual refresher approach, there are inconsistencies among care providers, which means that when staff moves between organisations through turnover, there are often huge knowledge gaps. This contributes to a general industry issue that new staff is not up to date with evidence-based practice, as they may fall in between training cycles. Likewise, there is no requirement for training to be accredited, which means that anyone within the organisation, or any external training consultant, can develop and deliver their training module. A lack of certification also means that staff cannot use this as part of a continuous development programme leading to formal qualifications. The impact of this is that staff do not take training seriously and attend simply for the sake of compliance. The most common feedback from providers is that it is therefore challenging to motivate staff to attend training, learn and apply new knowledge in practice.

To address certification of training, providers would need to send the staff member to attain a higher qualification such as Level 3 in Adult Education Training (AET). This teaching qualification is designed to equip staff who work within the respective organisations to become trainers so that they can deliver education in practice. As there is a cost associated with this type of training, most providers do not see value in investing in it if they are required by the Commissioners to meet minimal standards in training. There is a concern that once staff develops training skills they will become marketable and leave the organisation as highlighted by the National Skills Academy for Social Care (NSASC 2011).

Having worked in the industry for 18 years, I have observed a lack of consistency in training strategy across the care homes contributing to the challenges faced by providers to meet care needs. The government tried an initiative with Skills for Care to support the industry through provision of learning resources at no cost to try and ensure front line staff have access to the same materials. However, given there are around 25,000 care homes nationally, NSC's reports indicates engagement with only one-quarter of providers. This is because there is no legal requirement for providers to engage with this organisation or use their resources, despite being free of charge. The other issue is that training is viewed as a compliance requirement and so is delivered with a focus on achieving compliance as opposed to providing meaningful continuous practice development (CPD). The outcome of this approach is that providers only become active in thinking about training in periodical cycles towards the time when their staff

training requires updating or when they are due to have an inspection. Therefore no incentive for them to proactively do anything else in-between.

It is my view that to understand the problems associated with learning in the industry, core challenges that impact the industry's performance and care standards need to be identified. I believe these would have a significant and indirect influence on learning culture and impact on how education within such a learning environment as proposed within the case study could be funded and supported across the industry if proven to improve standards of care. The UK care home industry is growing faster than the resources available to support and meet demands. Currently, there are about 6,000 operators who manage 13,000 nursing and 7,000 residential care homes across the country. There are 6 million elderly people aged 65 years or above and this number is expected to rise to 8.5 million by 2035 according to the Office of National Statistics 2020. Whilst more residential and nursing beds will be required in the next 10 years, the biggest challenge is the current 6 million, the number of residents aged 85 years and above requiring higher levels of nursing care is 3.5 million. This trend indicates that the demand for complex care beds in the future will increase as will demand for specialist skilled and competent staff to support those residents. If current training is not meeting current needs, more complex future needs in larger care home population will strain the industry to breaking point.

This is due to the fact that as elderly people living much longer, they develop age-related frailty, complex care needs and comorbidities that require specialist care support to meet their activities of daily living. Importantly, this is reflected in this research's case study whereby the average age of admission at NH is around 92 years, and across the industry at 85 years. Furthermore, at NH 10% of care home residents are over the age of 100 years which is also reflected within the industry trends as more homes have more "super-aged" residents in their care compared to 10 years ago. In 2020, the average length of stay in a care home is around 1,000 days, whereas seven years previously it was around 1,800 days or more. As people are generally living longer at home, by the time they come to a nursing home they near the stage of requiring end-of-life care (EoLC). This type of care requires specialised training and skills in early symptom identification and planning the right intervention, including administration and monitoring of complex palliative care medication management. This used to be the role of hospices, but as the elderly population is growing and more people are surviving into centurion years of age, care homes are fast becoming the hospices of the future.

This trend presents a challenge that a different model of building care packages is required to meet future blended needs. In the UK, there have been five main care categories designed to meet care needs as illustrated in Figure 1.2.

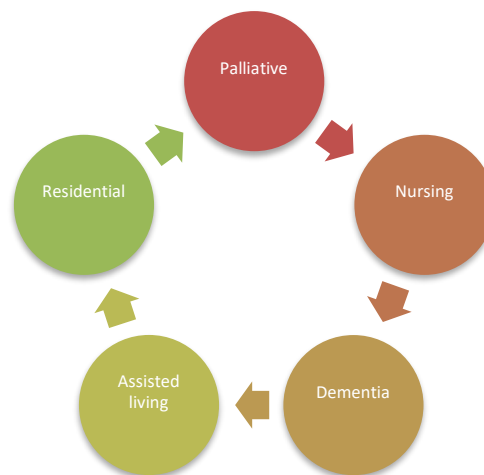


Figure 1.2: Care types Source: created by Author (2019)

It has been possible for each care home provider to be registered as a provider for either residential or nursing beds. Typically, nursing homes provide nursing, with either a specialty in dementia and palliative care while residential homes provide only assisted living, residential or dementia care. Given the changing trends complex care needs as people are living longer, it is no longer possible to only keep residential or nursing resident separate within their distinct care domains. However the training system currently has not evolved to match the emerging care trends. A combination of high nursing, dementia and palliative care residents in a single residential care home presents huge financial and workforce challenges as the provider needs to swiftly recruit or upskill staff in short periods of time. Often resulting in high agency use where they fail to recruit adding to work related stress and work overload. I have experienced how this results in understaffing, sickness and absence.

An additional challenge is managing relatives' expectations when they are struggling to accept their loved one's changing health condition which places a lot of pressure on clinical teams. These situations demand well trained staff who have comprehensive and proficient skills. Additionally, confidence and resilience to respond to emotional, physical, medical, clinical and social needs all at the same time. It is believed this industry situation is highlighting the fact it is no longer practical to only have a basic skill mix only specific to either residential or nursing

registration as care needs are blended across the five categories in most homes. Therefore it has to be considered that providers have to come up with a workforce development model that proficiently responds to these blended needs.

Future care demands specific to dementia should also concern providers already struggling to support their existing workforce to meet care standards. According to the Alzheimer Society (2019), around 850 000 people are living with dementia in the UK and 35% of them are in care homes. Further, this percentage is projected to rise by 35% by 2040, and an additional 45% by 2050. The Alzheimer Society outlines that one of the biggest challenges the industry is facing is that 70%-80% of residents in care homes have dementia, whereas 15 years ago the percentage was 55–60%. Dementia care requires specially trained staff who understand how to assess, anticipate and support the mental, psychological and physical symptoms exhibited by residents with dementia. This includes distressed reactions or behaviours both physically (hitting, punching and kicking staff or other residents) and psychologically (shouting, screaming and anxious or paranoid behaviours). Such a workforce requires not only knowledge and training in dementia care, but most importantly, skills and competencies to respond to care needs and prevent serious self-harm or incidents between residents, staff, relatives or volunteers.

Whilst the Industry has been growing it has however been destabilised not only by the changing economy but also by political issues such as ‘Brexit’. While 1.58 million staff are employed in the care industry, there has been an increase of 19% in job vacancies over the past year alone according to the Office of National Statistics (ONS). Following the confirmation of Brexit and the uncertainties it has brought, it is estimated that 30,000 staff from the European Union are likely to leave the industry to return home. This political climate is considered to be contributing to workforce challenges such as attracting and retaining the right staff, and other factors that have a direct impact on the resources available to care home providers to deliver a high quality of care to residents. Based on my years of experience in the industry, I have observed how this has in the last couple of years presented a huge challenge to providers already struggling to provide cost-effective care while also dealing with high complex care needs, which require more resources such as nurses with proficient skills and competencies to meet required standards of care. Where this has not been managed, it has led to high staff turnover as existing staff cannot cope with the work pressures.

Turnover of staff also contributes to huge recruitment challenges, uncovered vacancies and a continuous flow of new staff whose culture is not embedded in the organisation. This has led

to poor CQC ratings in 21% of care homes and an increase in the number of complaints, neglect and safeguarding issues in care homes across the country. The recent reports from the CQC 2020 indicate a rise in the incidence of abuse in care homes with charities like Age UK highlighting a national crisis and calling for urgent intervention from health ministers to reshape the system.

1.4 Research Questions

The problematic situation described above generated the following research questions that will be addressed in this thesis:

1. How is learning currently delivered at NH and how does this differ from the care sector?
2. What kind of transformation occurred as a result of the learning delivered at NH and how relevant was it to the improvement of standards of care?
3. What are the common challenges and constraints NH experienced and is likely to experience in the future?
4. What are the lessons learned from the past decade of investment, activities, success and failures related to the home care industry in the UK and what recommendations can be made?

1.5 Research Significance and Objectives

To fully understand the full context and relevant factors and evaluate the impact of a learning environment at NH, the following questions were designed to analyse and

1. Assess learning practices at the NH care home and further explore and reflect on how the learning environment at NH affects its standards of care
2. Comprehend common challenges and constraints faced by the care home industry in this area and evaluate lessons learned
3. Identify NH's KPIs applied to effect improvement and how the role of learning activities is perceived by stakeholders

4. Evaluate current practices at NH against the known standards of care and consider what contributed to it progressing from 'good' to 'outstanding'
5. Make recommendations and suggestions for how proven methods and impactful learning outcomes can be cascaded across the industry.

Chapter 2: Literature Review

2.1 Introduction

This chapter begins by outlining the relevant aspects of the field of care home industry before turning to a review of the literature on the characteristics of learning in care homes and its relevance to improved care practices. The chapter reviews the efforts currently being made to establish learning environments as well as the problems faced by the industry's current learning practices as a contributing factors to gaps in knowledge. It argues that further research is needed in the area but finds that much of the literature lacks an effective theoretical foundation. The literatures of learning in educational institutions; acute health care settings and hospices studies are reviewed in terms of their treatment of learning approaches. However, it is concluded that, although the latter two are relevant, they provide very little coverage of learning specific to the nature and diversity of the workforce found in care homes, and the type of skills required to maintain practice autonomously without the immediate support of medical or specialist teams.

2.2 Defining Learning in Contemporary Organisations

In view of limited research and conceptual frameworks for learning definitions in the care home industry, the literature search explored definitions used in other contemporary industries such as education (schools, colleges and universities) which are well established in this subject. De Hovwer et al. (2013) define learning as a process in which students gain knowledge through participating in activities that challenge and modify their behaviour permanently as a result. He considers learning not to be an event but a continuous sequence of activities tailored to change the thinking and actions of the student. Another definition of learning, suggested by Biesta (2018), is that learning occurs when social outcomes are altered as a result of new information that has consciously influenced the participant. The overall consensus on the contemporary definition of learning is that the general outcome of the participant—either student from an education perspective or learner from an employee's perspective—is that they act and behave differently as a result of engaging in the process.

This definition is similar to that used by Illeris (2018), who describes learning as an approach that uses structured steps to support understanding but is only applicable when the knowledge transforms the actions of the learner. These definitions bear little resemblance to current

practice within the care industry: Skills for Care (2016) offers training as an activity where staff participates in a session or workshop to gain new knowledge. This approach implies that a single event is sustainable and sufficient, contrary to those of Biesta (2018) and De Hovwer et al. (2013). This difference in the definition may explain differences in approach: contemporary industries focus on transformation through knowledge whereas in the care industry there is a focus on attendance or participation in single events without an outcome focus for sustained change.

Illeris (2018) suggests that the theory of learning should be defined by continuous interventional steps of introducing information, applying context, reviewing understanding and measuring outcomes to achieve transformation or change in the learner's behaviours or action. He suggests that for this to take place, consideration of different learning approaches must be made to accommodate different learning styles. His first suggestion for effective transformation is the application of cognitive learning whereby learners gain knowledge through thought-provoking exercises and experience. Dekker et al. (2012) support this point and outline the different types of learning styles as kinaesthetic, auditory, visual, reading or writing. They further emphasise that it is imperative to ensure that learning is tailored to support different styles, for learners to retain information permanently and be able to create understanding.

Illeris (2018) adds that another learning style that would be applicable in an adult work environment is observational learning, which involves learners observing someone carrying out an activity, task or behaviour that they in turn will remodel. He suggests observational learning is secondary to cognitive learning in that it can be used to reinforce the theory and help learners with how to conceptualise the application of knowledge in practice by observing someone who is modelling how it is done. Bates (2016) confirms that in a workplace environment, this style of learning is more applicable and relevant as it also leads to practical outcomes that relate to the development of knowledge and skills. Skills for Care (2019) identifies that lack of knowledge, skills and competencies is a major contributing factor to underperformance in the industry. Their findings support the notion of Illeris (2018) that outcomes for performance in practical subjects can be developed through observational learning. Dekker et al. (2012) concur that learning is not only achieved in the classroom setting and via the academic route. They propose that there are other ways in which different learning styles can be supported in different settings or environments. They identify reflective practice

as critical to help learners consider what they have learnt, how they feel about the new information and how they think their practice could be changed in relation to this new information.

Dekker et al. (2012) explain that reflective practice can also be based on events or activities that have occurred, with learners having to consider what or how things could have been done differently to achieve alternative results. Gibbs (1988) proposes a reflective model that supports the ideas outlined by Dekker et al. (2012). He states that reflective practice improves the understanding of practitioners to connect their feelings, experience and consider how they can improve. Gibbs (1988) believes that reflective practice is one of the most effective ways to encourage learning, especially in a work environment, as it involves real incidents that are applicable and relevant to the roles and practice scope for knowledge and understanding. Dekker et al. (2012) concur with this view and add that involving case studies in learning is another way of making the application of knowledge more relevant to the learner and the field or subject in which they are seeking to improve understanding. They explain that case studies evoke a practical analysis of live scenarios and helps learners to listen or read the case, and discuss and explore ideas around the subject. Bates (2016) concurs this process connects with learners who are readers, writers, listeners and visual learners, especially if there are other methods of presenting the case study such as PowerPoint presentations.

De Hovwer et al. (2013) do not disagree with the idea of reflective learning being as useful as an alternative way of learning approach called associated learning. This involves learners using past experience as a guide and understanding what will benefit them and their future outcomes through the association of previous results obtained by taking certain actions. They suggest that where the practice is concerned in work environments, people typically follow known procedures and use the same approach they previously took to achieve those outcomes as a guide to attaining future results. They add that sometimes associated learning is useful for consistent jobs or activities that require the same actions to achieve the same outcomes; this is also associated with conditional learning. Gibbs (1988) completely disagrees with the notion that conditional learning is the best approach as he suggests that with every past experience, there should be an opportunity to reflect and consider how things could be done differently to give the learner or worker the opportunity to improve by taking a different approach to the same action. The National Skills Academy for Social Care (NSASC 2020) agrees with the analysis by Gibbs (1988) that it should in turn alter the outcome, hopefully for the best. He

suggests that this not only leads to better practice outcomes but also improves the performance of staff, unlike conditional learning where the same approach is used all the time.

2.3 Defining Learning in the Health Care Industry

My literature review identifies that there has been some research in the acute health care industry (hospitals and hospices) relating to the subject of education, workforce development and standards of care, but nothing about learning and a learning environment, especially in the care home industry. The most relevant research was conducted by the Skills for Care—Workforce Intelligence. The group produced an analysis report in September 2017 following extensive research of the health care industry in the UK regarding the impact of workforce development through learning (training and education) in the workplace and how this improves staff performance. The research defined learning as the provision of education through training to support and develop staff working in the care industry. Unlike De Hovwer et al.'s (2013) (see Section 2.2), this definition does not include key points such as knowledge transfer that is permanent and designed to change the behaviours and actions of staff.

The other main difference in definitions between the care home industry and other contemporary industries such as the education sector is explained by Skills for Care (2017). The care home industry outlines training whereas definitions from education industry are specific to education through teaching, activities, challenges, behaviours and outcomes. Alternative definitions of learning outside the care home industry seem more clear and comprehensive, setting out higher standards and expectations. The use of teaching in the contemporary definition versus training in the care home industry definition also signifies that the contemporary version is concerned with long-term engagement with learners as opposed to training, which can be considered occasional or just sessional. The impact of these differences in the definition is significant as it can explain why the care home industry has a short-term focus on knowledge transfer based on a compliance-driven approach to ensure that staff attends mandatory training sessions annually, rather than an alternative approach of investing in long-term continuous development via education with a primary focus on improved measurable practice outcomes through teaching.

Research published by the health care industry's training organisation called Skills for Care in 2019 seemed the most relevant concerning learning in the care industry. It had interesting aims, objectives and outcomes that were examined for this research to determine if they were relevant

and could contribute to the DBA research question, as it is associated with learning in a care workplace. The Skills for Care research concluded that training and education have a positive impact on how staff performs in their workplace when delivering care. Scrutiny of the research field, participants and conditions under which they worked revealed limitations in that the study focussed only on clinical staff such as nurses and doctors, who are in charge of the standards of care in more acute settings (hospitals) of the health care industry. This research did not include any staff who worked in the social setting (care homes) of the health care industry.

Patients in the acute sector (hospitals) of the health care industry on which the research was focussed are much younger (0–75 years) than those in the social sector (care homes) of the industry (80–100 years). This is critical as the key drivers and challenges of providing high standards in care homes are strongly affected by the complexities of an ageing population. The NSC research was limited in scope as it focussed solely on the clinical workforce, which is not part of the residential or nursing care home workforce structure in the care home industry. General research findings specific to the care home industry are therefore limited as direct comparison or application is not possible regarding the contribution of staff learning to standards of care. Further, the standards of care in hospitals and care homes are slightly different because of the nature of care they deliver, although both are regulated by the CQC.

The Skills for Care (2019) research does have several parallels with the current study. The first is the similar composition of learning, consisting of training, skills and practical competencies for staff delivering care which is highlighted in both studies to be necessary. Unfortunately, it did not link learning to standards of care to evaluate its impact on the performance of hospitals where this occurs. Had such a link been established, this would have contributed to the research aims of the current DBA research. Which is to explore this phenomenon and establish both a definition for the learning environment and how this can be used to address challenges and poor care standards specific to the care home industry.

The above research conclusions include that this is achieved by supporting confidence in skills and competencies, which will have an impact on the consistency of learning and improving clinical performance. However, the research did not go as far as defining what kind of environment is considered suitable for learning in a care setting; how it can be developed; and whether the clinical performance of individual staff is directly linked to improvement in overall care standards. The current DBA research attempts to bridge this research gap by defining a learning environment and exploring the direct relationship or impact it has on care standards

in the care home industry. There are also gaps in the recent Skills for Care (2019) research in relation to its focus on the participant group. That research assumed that doctors and nurses have the most influence on care practice in acute care settings. This is in contrast to the findings of earlier research commissioned by the UK Government in 2014, led by Sir Robert Francis QC (government advisor and barrister in medical and care matters). His inquiry-led research into the care home industry followed serious widespread allegations of abuse and poor standards across the industry. Its findings outlined that there was a direct relationship between poor care, lack of training and leadership support from care home managers.

2.4 Defining Learning in the Care Home Industry

Francis (2014) suggests that HCAs have the most contact with residents and should therefore become the central focus if the industry is to improve standards of care. He thus made recommendations for training to be remodelled, not only to change the way care is delivered but also to empower HCAs so that they have the skills to make decisions while working with vulnerable residents. Francis's (2014) top recommendation was that the work environment needs to have a culture of learning to encourage development and support for front line (HCAs) and clinical staff (nurses). The recommendations of Francis (2014) were widely accepted as the most relevant and applicable for the care home industry, although no further research evidence provides a model for how to apply this into practice. For the purposes of this DBA research, Francis's (2014) findings and recommendations justify exploration of research gaps by linking the culture of learning to changes in the way care is delivered by the front line and clinical staff that represent the care home workforce. The current research uses the findings from the in-depth studies of Skills for Care (2017) and Francis (2014) to develop definitions for the key principle elements of the research question, which were not identified in the literature review.

Skills for Care (2016) defines learning as a process of improving specific knowledge and skills among relevant care staff (nurses and HCAs). Chaiter et al. (2015, however, argue that learning is not only about knowledge and skills, but how this is transformed into practice to influence how care is delivered. He emphasises that learning needs to be connected to the outcomes of the roles that staff are employed to perform and the process of evaluating whether their objectives are being met following the new knowledge and skills provided. Wright et al. (2015) concur with this notion and add that to complete the cycle of learning, there should be scheduled supervision and appraisals that link the learning objectives to the practice objectives

so that progress and outcomes are well defined and measured against expectations agreed between the supervisor and the supervisee. Wright and colleagues emphasise the importance of having this clear process as it allows the learnt theory to be exercised in practice and provides an opportunity for both parties to evaluate progress and thus consider any further action that may be required to tailor the approach to provide intended outcomes.

Wright et al. (2015) believe that the process of supervision should be considered part of the learning process in addition to the training provided. They suggest that when training is provided and not linked to any form of appraisal, this creates an incomplete process that does not allow knowledge to be translated into action. They further highlight that managers and supervisors miss the opportunity to provide the level of support, monitoring and guidance that staff needs to feel encouraged to practice what they have learnt. Chaite et al. (2014) cite this in their argument that learning is not only subject to staff gaining knowledge through training but rather, it is paramount to build support around staff so that they can continue to use newly acquired information and knowledge in their practice. Both Wright et al. (2015) and Chaite et al. (2014) do however acknowledge that learning in a work environment is much more challenging than in a classroom or educational facility as support is not always available because of work demands on managers and clinical leads who are supervisors and have other competing priorities. Both highlight the importance of organisations having systems, procedures and processes that prioritise and protect time for learning to occur. Further, they emphasise identifying and investing in the resources needed to ensure that the process of supervision is conducted effectively and consistently for the learning cycle to be completed.

Chaite et al. (2014) define two categories of learning within a work environment. They refer to formal and informal learning that can be undertaken either individually or in combination. They claim that formal learning consists of education delivered through face-to-face sessions, training courses and formal assessments such as tests to measure understanding. They define informal learning as coaching, supervision and observation of staff to support their skills and competencies while working. This definition of two categories provides a clearer understanding to influence learning in the care home industry. Chaite et al.'s (2014) structure of identifying what constitutes learning cycles is relevant to this research proposal: the definition of learning is a process of developing care home staff knowledge to advance their skills and competencies through a CPD plan. This definition consolidates all literature findings

regarding the learning cycle, from formal and informal learning to measuring outcomes in practice to ensure that knowledge is transformed into better care practice.

Based on the literature review and definitions of learning adopted from the contemporary, health care and care home industries, this DBA research considers that a learning model that can be applied to care homes consists of the following components:

1. **Knowledge.** Chaiter et al. (2014) define knowledge as the practical and theoretical understanding of a subject. They define training as a process of teaching staff to improve understanding of a particular subject area of practice based on intended learning objectives and outcome measures. It is established by Wright et al. (2015) that effective education to improve knowledge is built on induction, supervision, appraisal and review processes to evaluate the learning objectives for each staff member to ensure that the correct information has been provided to improve understanding and change the staff attitude, behaviour and performance. This is in line with the CQC's (2020) expectation, defined in their fundamental standards, that providers should ensure staff have annual mandatory training sessions on key subjects that are thought to support good care. Moreover, they should provide periodic supervision and appraisal mandatory for all staff. This suggests that staff who know the protocols, procedures and clinical practice will perform better in their role in delivering good care.
2. **Skills.** Wright et al. (2015) define a skill as the ability to perform a task well. The most common skills required in care homes are intervention to manage symptoms of common clinical conditions such as diabetes and pressure ulcers, and use catheters and percutaneous enteral feeds to manage common elderly care-related comorbidities. Staff require not only the knowledge of what these conditions are, but the confidence and ability to complete intervention procedures effectively. Most care homes with high staff turnover will not be able to care for residents with these conditions if they do not have staff available 24 hours per day to respond to those care needs. This results in residents being sent to hospital for short-term interventions, which affects their wellbeing as they are constantly being transferred and put at risk of hospital-acquired infections.
3. **Competencies.** Skills for Care (2019) defines these as the ability of care staff to complete a procedure efficiently. Competency assessments are considered a measure of how staff are able to demonstrate transfer of knowledge and skills into practice and become the defining factor in whether or not learning has occurred. Being the

Government body responsible for setting training standards in the care home industry, Skills for Care expect that care staff will have the knowledge and skills to be able to demonstrate efficient practice of procedures in care. However, there is no existing framework to support how competencies are defined for each role and clinical procedure and how this should be assessed.

2.5 Definition of a Learning Environment

The literature review also explored the definition of a learning environment where learning can be fostered to provide the best outcomes. The most common understanding in the reviewed literature around a learning environment widely assumes a physical location that provides a diverse context, experience, culture and practice for students or learners to learn, as outlined by Power (2014). The review found that this definition is mainly used in the academic and educational context, although the principle is applicable to the workplace environment (Power, 2014). Further, the concept of a learning environment has been introduced in the health care industry (hospitals and hospices only) in the last decade. The most prominent examples are Guys Hospital and St Thomas University Hospital, and St Christopher hospices in the UK, which have partnered with universities to provide accredited education in practice for student nurses and their care staff within hospital/hospice settings.

The literature review identified that the care home industry has not adopted this concept at all. Also, no research has specifically explored this concept with the participant group that is the focus of the current study, suggesting huge research gaps that need to be addressed. An extensive literature relates to types of learning environment within the business and education industries, with application in the care home industry. Wright et al. (2015) define a learning environment as the cultures, attitudes and philosophies held by the organisation in regard to staff learning in the work environment.

Hannigan (2016) explains that a learning environment is defined by an organisation's systems, structures and procedures to promote learning for its workforce. His notion is that having a clear vision, learning objectives and measurable outcomes that are specific to each level of engagement or role within the organisation is key to a learning environment. Hannigan (2016) believes that for learning to take place, there must be a link between the inductions of learners; their supervision, to assess current knowledge gaps and identify development needs; and the observations carried out, to evidence performance. Notwithstanding what Wright et al. (2015)

denote as culture, attitudes and philosophy, Hannigan (2016) adds that without a defined processes of how, what subjects are to be delivered and where, learning cannot be established just by just delivering training sessions. He outlines that having training budgets, trained and suitably qualified educators and a framework that connects learners and staff to education resources is fundamental to the culture that will develop and the attitudes that will manifest when information and support are readily available to promote learning. He argues that an absence of these systems and processes reduces a learning environment to simply training, which is spontaneous and does not have a detailed structure to deliver sustainable and measurable outcomes in practice.

Dymock (2014) proposes two types of learning environments that supports this. The first is an enabling environment, characterised by a positive culture where staff have appropriate resources such as courses, literature, facilities and mentors to support their continuous learning. The second is a constricting environment, characterised by a lack of systems, structures and opportunities for staff to learn. He adds that constricting environments are often accompanied by negative attitudes and a culture that is closed to the concept of new ideas, personal development and career pathways for staff. Further, Dymock (2014) outlines that the absence of a governance structure that clearly defines the standards of training required; the policies and procedures in which this training is delivered; and a quality assurance system to evaluate outcomes and performance of trainers are the main reasons for a constrictive environment. He suggests that for learning environments to be successful, it is imperative that an organisation establishes very clear steps, resources and performance indicators that can act as a guide and measure of success for both the organisation and the staff involved in the learning. This is supported by Wright et al. (2015), who outline that part of the system that has to be considered in a learning environment are the different learning styles that staff or learners will have.

Wright et al. (2015) advise that a comprehensive learning environment should have resources for visual, kinaesthetic, auditory learners and readers or writers to ensure inclusivity and support for all groups of learner. However, they do not link the availability of resources and approaches to accommodate all learners to overall better outcomes and performance for learners and the organisation. Although their research was mainly based in the education and business world, it does apply to learners who are staff working in the care industry. The literature review deduced that this often contributes to the challenges of turnover, as staff seek

development elsewhere resulting in the cycle of shortages, high agency use and inconsistent care delivery.

Having established the definition of learning and searched the literature for information on learning environments, this research now proposes the following definition for a learning environment: a care home setting that has a learning philosophy within its processes and procedures of delivering care. Philosophy in this definition is characterised by a positive attitude and culture that encourages staff to learn and develop continuously (Power 2014). This learning environment definition has been created specifically to model the concept of a learning care home as it sets the right expectations to address the workforce competency issues faced by care homes as they try to meet appropriate standards of care.

2.6 Importance of Learning/Training in the Health Care Industry

Power (2014) states that it is important to define and establish common standards to allow comparison of the performance of different organisations in the industry. This also provides the basis for evaluating what is contributing to the differences in care standards across the sector and identifying what interventions can be impactful. In its guidance to care homes, the CQC identifies its responsibility for setting, regulating and enforcing standards of care in the UK (CQC, 2019). These standards are defined within the *Care Act 2014*, which outlines 16 fundamental standards with which each registered provider is required to adhere, by law (CQC, 2019). This is echoed by Skills for Care (2015), which is responsible for supporting care homes with workforce development to meet these standards of care, and explains that the regulations cover operational, statutory and regulatory expectations, with regard to which each provider will be inspected every two years, or annually if there are concerns about their compliance.

The National Skills Academy for Social Care (NSASC, 2020) emphasises that CQC's use of the Short Observation Framework for Inspection (SOFI) in which specially trained inspectors conduct unannounced visits to care homes is efficient, and critical for standardising expectations around care standards across the industry. This is reiterated by Chief Inspector Sutcliffe (2019) who outlines that the process includes an analysis of how care is delivered; review of records of care; observations of staff working with residents; and interviews with residents, relatives and staff to gauge how well standards of care are being met. The CQC (2019) had introduced, in the previous four years, a method of rating each provider against the fundamental standards of care to summarise their findings from each inspection.

The 16 fundamental standards are categorised into five KLOEs that establish a benchmark for performance in the industry. The KLOE standards are provided in Table 1.1.

Table 1.1: Five KLOEs

Safety	The standards examine providers' management of accidents, incidents, and health & safety processes/procedures. They review whether the organisation is reporting incidents to the relevant bodies and that safety concerns are followed up effectively. There is an expectation to show evidence of learning to prevent re-occurrence. This KLOE seeks evidence that resident care is delivered safely in a well-maintained environment.
Well-led	Organisations have suitable and qualified management staff that provide leadership that promotes good practice. The most important is support staff development and a positive culture of transparency so that staff deliver good care and raise concerns without consequences for them as a 'whistle-blower'.
Caring	Care is person centred and designed around the wishes, preferences and needs of each resident without any institutionalised practice. Where care needs are complex, the right staff and specialists are involved to ensure continuity of care.
Responsive	If concerns or safeguarding issues are raised (e.g. neglect, physical or financial abuse), the organisation has good procedures in place to investigate, follow up and resolve the concerns. This KLOE also explores whether providers have strategic plans in place to make improvements or plan for foreseeable trends relating to their service before situations arise.
Effective	Each resident has a care plan that is meeting their care needs; care is reviewed and evaluated to accommodate for change and facilitate each resident's independence as much as possible. This domain also explores the way organisations collect data through audits to analyse trends, inform decision making processes and include residents, relatives and staff to improve care through their feedback.

Source: created by Author (2020)

Power (2014) argues that for improvement to take place, there has to be clear definitions of expected standards that establish appropriate benchmarks enabling organisations to compare

their performance and identify areas for improvement. Following a CQC inspection, a care provider will receive its rating of performance against the care standards (KLOEs) in the rating categories outlined in Table 1.2.

Table 1.2: CQC ratings

Inadequate	The provider fails to meet two or more of the standards in the five KLOEs
Requires improvement	This is when a provider has met some of the fundamental standards within some KLOEs, but may be lacking in one KLOE, which may be inadequate but showing progress to improve care and compliance
Good	This is when a provider is demonstrating good evidence of meeting care standards in all the KLOEs
Outstanding ★	Awarded to a provider showing consistent compliance and demonstrating creativity, innovation and excellent evidence-based practice in their care delivery

Source: created by Author (2020)

CQC (2019) outlines the reasons for each rating using a traffic light colour system from red for ‘inadequate’, orange for ‘requires improvement’, green for ‘good’ and green with a star for ‘outstanding’. This provides a simple guide that care providers, residents and staff can easily understand and use to identify the areas they need to work on to improve their standards. The results for all providers are published on the CQC website for public viewing and publicly show whether an organisation has poor standards or not. CQC does not provide a guide to improving standards based on its experience of inspecting the industry. It is left to each organisation to independently resolve any issues. This gap in knowledge may be filled by the current DBA research through consideration of the constitution of learning. Figure 2.1 depicts the current inspection outcomes for all providers, revealing the overall standards of care across the industry.

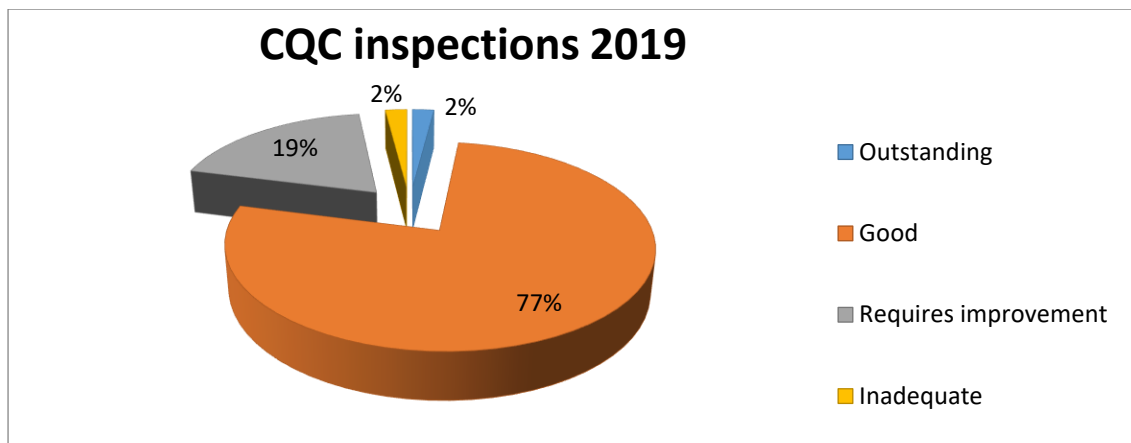


Figure 2.1: CQC inspection results (2020) Source: created by Author (2020)

Sutcliffe (2018) raises concerns about industry standards varying between providers, with a particular concern being that 21% of providers do not meet all of the fundamental standards. Industry critics also express concern that the number of care providers that are inadequate is similar to that who are ‘outstanding’ in terms of standards of care (Care Matters, 2020). Sutcliffe (2018) further explains that from a resident’s perspective, depending on where one is in the country, one has a choice of a very poorly performing care home or one that has high standards but will be charging more because of high demand hence unaffordable for most potential residents. Analysis of the recent literature pertaining to care standards (see Figure 2.1) reveals that the percentage of inadequate care homes in 2020 had increased by 0.2% from the previous year, signifying that whatever interventions were being applied have not been suitable or sufficient to produce significant improvement.

The literature review also established that care homes in the categories ‘inadequate’ and ‘requires improvement’ did not improve their standards over two consecutive inspections. This implies that CQC’s approach, involvement and expectations did not influence the performance of those care homes. Figure 2.1 highlights the fact that only 1% of care homes within the industry at the time of the report were in the outstanding category. This observation is supported by Skills for Care (2019), which conceptualises that such a low percentage of outstanding care homes in the UK demonstrates how challenging it is to achieve that level of accreditation, given the condition in which care homes are delivering care.

This observation furthermore reflects the suggestion from Francis (2014) that standards expected of care providers are not easily achievable by most providers rated as ‘good’. However, he adds that meeting the outstanding category in standards of care is not impossible

if the care home changes the way they support education, staff's capabilities and culture. The literature review has demonstrated huge potential for the 77% of care providers to become outstanding, which could change industry trends and negative perceptions of poor care in the industry. Nonetheless, leading industry experts warn that because of challenges in the industry driven by demographics, cost of care and staffing issues, the percentage of care providers rated as 'good' (77%) may deteriorate in standards over the next three to five years unless they identify the key issues and challenges they face, and how to address them (Care Matters, 2020).

The literature review also sought to identify the issues likely to impact on care standards, and explore whether these were considered in previous research, and what the outcomes were. This aimed to reveal aspects of intervention that should be central to the definitions of learning and what a learning environment should encompass. The care home industry has identified the most common challenges faced by care operators that have a direct impact on their work environment, where learning should take place:

- **Recruitment.** There is a general shortage of skilled staff within the industry, with 15–20% vacancies across care homes. This is important as skilled staff can teach, coach and train others. Care home providers end up using agency/temporary staff that do not know the organisation well enough to contribute to the standards of care. Recruitment is also driven by the CQC rating: industry surveys by Care Market (2018) suggest that care providers rated 'inadequate' or 'requires improvement' struggle to fill vacancies on average 25% more than a care home rated 'good'. Care Market (2018) also states that new staff require training to develop their skills to work in the new role before they can contribute to standards improvement.
- **Retention.** Skills for Care (2016) states that it is important to maintain a well-developed workforce that is familiar with the processes and procedures of the organisation as this helps to maintain consistent levels of care. This is also stressed by Fitzpatrick et al. (2014), who add that retention is important to build a therapeutic relationship with residents, and builds a better caring environment that promotes wellbeing and learning. Care Market (2020) identifies that staff turnover is costly because of recruitment fees and the expense of replacing leavers with costly agency staff. They conclude that training budgets are reduced to balance costs, which affects the development of staff. NSASC (2019) reports a care home turnover rate of 18–25% (higher than in other industries), mainly for care providers that are inadequate and require improvement. Skills for Care (2019) suggests

there is evidence of high staff migration from care homes rated ‘inadequate’ or ‘requires improvement’. It can be concluded that if care standards improve, staff will be retained.

- **Skills.** NSASC (2019) advises that given increasing frailty, complex care needs and palliative care demands, care homes require staff with more than just mandatory training but rather education that provides knowledge, competencies and skills to respond, manage and coordinate care with other professionals. Sutcliffe (2019) states that during CQC inspections, care homes rated ‘good’ or ‘outstanding’ demonstrate effectiveness in maintaining training, skills and competency levels.

Fitzpatrick et al. (2014) identify that these challenges are faced equally by private and charity care homes, although the impact is reduced by the ability of an organisation to anticipate, plan and adapt its response to manage the challenges. He further argues that the common factor in these three challenges is how they relate to the environment where staff work, what training they receive and whether they can use it consistently in practice to influence the type of care they deliver. The Skills for Care (2019) conceptualises that effective skills development can increase retention and reduce turnover of staff as their ability to manage complex care issues creates a safe environment to work and reduces work related stress. Moreover, the ultimate outcome is a positive environment where staff learn and develop competencies that are relevant to the residents and clinical challenges they face in practice. The literature review interpreted this as an important factor to consider when defining a learning environment for the current DBA research project, as there is limited information or research linking the challenges faced by the care home industry to solutions related to staff skills, retention and recruitment and how each contributes to the quality of care.

2.7 Strategy and Policy Aspects

Evidence from the literature suggests that current practice in the industry involves care providers focussing only on formal training in mandatory courses outlined by CQC within the 16 fundamental standards (Hannigan, 2016). Examples of mandatory training topics are health and safety, infection control, moving and handling, safeguarding, person-centred care (PCC), medication management, fire procedures, food and hygiene, and falls prevention (CQC, 2020). As these are minimum requirements for training, most care providers focus only on these areas to ensure compliance and obtain their CQC rating.

Skills for Care (2019) highlights that most care staff are not offered extra developmental courses as these are considered optional and costly. Fitzpatrick et al. (2014) point out that current training cycles in care homes only require two or three hours at most for each of the mandatory sessions, once a year; there is no requirement by CQC for the provider to ensure that staff have competencies following this mandatory training. The literature review has deduced that where there is an absence of training evaluation or the requirement to ascertain whether the training—or indeed the trainer—is effective in imparting knowledge to staff, there is a risk that learning does not occur.

Research by Skills for Care (2019) into workforce development shows that around 70% of care providers use consultants who have established themselves as trainers within the industry; however, there is no requirement for these trainers to be accredited as there is no formal body to check their competencies. Clearly, training standards will vary depending on the provider selected by the care home. Skills for Care (2019) has also established that in most cases the decision about which training provider to use is based purely on cost effectiveness. Their appraisal of this approach is that training services are often designed and tailored to suit financial needs (constrained learning) rather than the organisational need to develop care staff to meet residents' care needs. This finding is in contrast to the definitions of learning and learning environment proposed in section 2.4 of this thesis.

NSASC (2019) suggests that effective training should be structured in a way to define learning objectives and outcomes for staff. It further suggests that training should be followed by supervision of the staff member in reflecting on what knowledge they obtained and how they would put this into practice. However, since this is not current common practice in the care industry most care providers have a complacent approach that means they focus on training, supervision and appraisal as separate regulatory requirements. Attention is apportioned to ensuring that staff go through each of the processes annually or as required by CQC rather than on how a process can be integrated to facilitate staff to practice what they learn and develop skills and competencies that will improve the care they deliver.

Hannigan (2016) outlines that the main gap in workforce development strategies in the care setting is a culture of compliance when it comes to training and supporting staff. He warns that opportunities to develop individuals and build on potential are lost as training focusses solely on delivering knowledge without testing it to ensure staff can use it in practice. NSASC (2019) states this gap is widely considered to be affecting the industry, compounded by the fact that

when conducting inspections, the regulator (CQC) focusses only on ensuring providers are doing the minimum training required.

2.8 Summary

This chapter explored and provided some background, definitions and learning concepts relevant and applicable to care homes if adopted by the industry. It can therefore be concluded that in the context of care homes, learning is a process that allows staff (learners) to acquire permanent knowledge that will change their behaviour and how they carry out certain tasks. It has also been established that learning takes place in different ways, which may include observations, where learners watch demonstrations of certain tasks that they in turn will need to perform in practice. This is considered vital in supporting learners to watch, listen and observe the consequences and outcomes of applying certain techniques and understanding what the outcomes will be. It can be concluded that this is an impactful way to encourage staff to improve practical skills and competencies in the care industry, as certain care activities can only be learnt by observing proficient or skilled staff performing them.

Therefore, a comprehensive learning environment will consider different ways to deliver educations linked to staff CPD tailored to different learning styles for learners. The education replaces training and there are opportunities for staff to have time and resources to learn whilst working. This requires a different culture of the organisation needs to support learning through case studies, research and provide learning resources such as learning platforms that help to access to IT. Furthermore, to encourage staff to learn new things, a system to acknowledge achievements needs to be in place. Finally, research is identified as a way to create a climate or environment in which staff can be influenced to use evidence based practices as part of culture change which is critical in improving care practice outcomes.

Chapter 3: Research Methodology

3.1 Introduction

This chapter is intended to give the reader a sense of how the research was conducted. It begins with his personal context which includes my background, how I came to this particular project, and a brief discussion of own perceived biases. The research then continues by discussing the process and theoretical foundation for the fieldwork, before turning to the specific research design. Finally then concluding the chapter by appraising the research design according to the theoretical criteria of the chosen methodology.

3.2 Rationale for choice of Methodology: Case study

A learning environment within a care home is a new concept as care homes are typically considered places where nursing and residential social care is provided. There has been limited research on the specific subject that makes this research project most pertinent, especially given the current climate in which the social care industry is struggling to keep standards up. NH as the chosen organisation has improved its standards and the staff involved will all have different views on how this occurred. However, the research had to explore and consolidate NH's experience and form industry-wide applicable recommendations without losing the individual opinions, perceptions and experiences of participants.

Worthen (2014) suggests research philosophy is the credence with which research data should be collected from individual groups, analysed and applied to inform change at a macro scale. He outlines two methods that can be applied: epistemology, referring to data known to be factually true; and doxology, which refers to data believed to be true. This research selected an epistemology approach, as it sought to identify what knowledge staff had developed and how they had acquired that knowledge, and to determine why and how they were able to acquire it. Epistemology allowed me to evaluate the reality and truth of the data collected to validate truth or reason. It also allowed connection of cultural influences with the way staff think and thus the impact of education in practice. Epistemology also enriched the data collection and the way it could be presented, particularly given the research questions defined in section 1.2, which focus on specific lines of inquiry designed to explore knowledge and understanding directly via the people involved in education within the organisation.

I was aware that data collection in care homes regarding training statistics and outcomes might be affected by the methods in which data are recorded because of human error because, for example, most providers do not use computer systems to record and track training. However, NH has maintained electronic records since 2018, further, comparing the primary and secondary data to outcomes via performance-related indicators will help draw reasonable conclusions regarding the impact of learning in the organisation. This does, however, play to the disadvantage of epistemology in that it may be challenging to judge how perceptions contributed to the knowledge or belief that learning did have an impact on NH's outcomes. Needless to say, the research design already had this factored in to mitigate the perception issue. The research also takes an interpretivist approach whereby as the researcher I interpreted findings and how they contribute to the relationship between a learning environment and improved standards of care. Further, as the concept of a learning environment does not yet exist in the care home industry, information must be evaluated for its relevance to the research question, aims and objectives.

To examine systems and changes in care standards at NH, I collected secondary data relating to learning practices at NH. This information was compared with findings from primary data collected to seek evidence of what changes had been translated from theory into practice. This first set of secondary data consisted of current:

- learning and material used by NH
- learning records for staff who wished to participate in the research
- supervision for the participating staff
- appraisals for participants
- learning policy for the organisation
- assessments used (if any) for competencies

The second set of secondary data collected included quality assurance audits for the areas in which the participants worked, and reports of accidents, incidents and complaints that related to staff. Evaluation of these data together with NH's CQC reports for 2016 and 2018 was used to identify any links between the education provided, skills gained and any trends in changes in standards of care delivered.

3.3 Research Design

A number of research methodologies were considered for this research project, including grounded theory as a systematic approach to constructing a theory following methodical data collection and analysis. This methodology was not considered appropriate for this research, which has the fundamental aim of evaluating a single theory in relation to specific impacts on standards of care and therefore needs a more guided approach that follows a hypothesis already considered, as opposed to seeking to form a grounded theory. Another method considered was the phenomenological approach, which employs a qualitative method of research through exploration of the common humanistic experiences of groups of participants—as they engage with the learning environment, in NH’s case. Although the phenomenological approach employs a qualitative approach, which is most relevant to the aims and objectives of this research, its focus on common trends or phenomena within a group limits the researcher’s scope to explore variables. Further, any anomalies might prevent application of the research to the wider industry, which experiences a range of influencing factors leading to learning and standards of care. Also, the stakeholder groups involved in the research have diverse roles and contributions that may not necessarily have a common base.

Ethnography was also considered, but was discounted on the grounds that it is limited to studying people and cultures. To effectively evaluate the impact of creating a learning environment in a care home, it is paramount to also examine other contributing factors in the organisation, such as systems, structures, policies, procedures and resources available to staff. The most relevant approach felt to be most effective for this research was case study. It was chosen because of its empirical inquiry approach to investigating a phenomenon—in this case, how the learning environment improves standards in care homes. Case study is also in depth and allows analysis of individuals, groups or events that contribute to certain principles. This gives the researcher an advantage in being able to explore various contributing factors at different levels to provide more detailed and broadly applicable explanations and findings.

Using the case study method, this research took a qualitative rather than a quantitative approach. Peters and Halcomb (2015) suggests that an interpretivist philosophy is best supported by qualitative analysis of data collected as this allows a humanistic approach to analysing the data. This fits with the current research aims and objectives to understand the impact of learning on individual skills, knowledge and competencies, which is subjective to the learner and the person supervising them. Current practice in the care home industry takes a

quantitative approach that considers only the number of staff trained, to ensure compliancy targets of 80–100% are met. In view of the discussion in chapter one of this thesis, this is proven not to work; hence a different approach to understanding the impact of learning outcomes has to be considered.

The study thus employs an applied research approach designed to inform care organisations and regulators about real-life issues in the care home industry. The intended outcomes are practical solutions based on the research findings. Hence this research also takes a deductive approach, defined by Vaske (2015) as having a statement or hypothesis based on existing assumptions and testing it via a research strategy. Having explored the literature and extensive research of organisations such as Skills for Care (2017) and NSASC (2016), the hypothesis tested here is that learning and creating a learning environment defined in chapter 2 (literature review) will have an impact on improving care standards. However, this hypothesis has not been tested in practice to evaluate its impact hence this research provides an opportunity to do so for the specific target group of care staff. NH provides that perfect field to test the hypothesis in practice as they have already implemented a learning environment and their standards have been improving.

Having considered a qualitative approach, the strategy proposed for his research is case study. The reason for this choice over other suggested approaches such as grounded theory, phenomenological, narrative and ethnography is that case study will allow the findings to be applied to other organisations across the industry. The purpose of the research is to inform good practice and improve standards across the care home industry; the case study approach is best suited to achieve that goal. Further, the case study strategy offers the opportunity to closely examine in depth all practices, processes, attitudes and cultures within an organisation. As established through the literature review, having defined structures in place is important to ensure a sustainable learning environment that is effective in supporting staff's learning.

Another benefit of case study is the flexibility it offers to use an exploratory and explanatory process to gather information and define outcomes and findings. This is important for the research as providers facing the same issues will be interested in findings specific to those issues, even if in a different setting (e.g. residential v. nursing care home). A detailed review will provide the necessary information covering all aspects of care issues, making the research findings more relevant and applicable to a wider group.

To take the right approach, I considered a number of factors relevant to the methods used. No resources were required apart from stationary and recording equipment, which was already available. The selected organisation had an existing research and participation policy that defined areas of confidentiality, consent, data protection and good practice. The participant information sheet provided to potential staff who wished to take part also defined and covered areas of confidentiality. Another practical consideration I was aware of is the skills required to conduct the research. Having completed an MSc degree previously in the same research subject, I developed skills in data collection, communication (interviewing) and analysis of data. As part of the DBA, research methodologies were studied, and research and support from the my supervisor at London School of Commerce (LSC) was instrumental in providing skills and guidance on how to best structure and approach the research project.

3.4 Stakeholder Analysis

Learning at NH involves a number of stakeholders who each contribute to the learning environment at different levels. To facilitate understanding of the impact of learning within the organisation, I therefore mapped the internal and external stakeholders and considered who has power and influence in creating the learning environment. Table 2.1 identifies these key internal and external stakeholders.

Stakeholder group	Total number of people	Constitution of group
Senior Management Team (SMT)	7	Directors (finance, care, human resource [HR], procurement, facilities, admissions)
Trustees of NH	15	Chairman, President, support Trustees and Care Governance board members
Junior Managers Team (JMT)	7	Household managers for nursing, residential and dementia. Care managers and facilitators.
Care staff	180	Health care assistants (HCA's), team leaders, senior health care assistants, nurses, assistant practitioners, housekeeping and staff from various departments)
NH volunteers	200	Support in the activity department, households, projects, dining and fundraising

Multidisciplinary teams	18	General practitioners [GPs], occupational therapists, physiotherapists, dentists, district nurses
Agency or contracted staff	25	Nurses
Educators	10	Care managers, assistant practitioners, nurses, team leaders
Assessors	8	Practice development manager, Relationship centred care facilitator, Care manager, assistant practitioners

Table 2.1: NH stakeholder mapping Source: created by Author (2019)

The research sought to explore stakeholder groups and evaluate their contributions to the learning environment and organisation. As shown in Table 2.1, the key stakeholders with direct influence were educators, SMT, JMT, nurses, team leaders, senior HCAs and health care workers, who participated in the delivery and experience of the education, care and practice being evaluated. It was also considered that trustees were highly influential as they controlled and approved the budgets required to deliver learning under the new approach taken by NH.

Having selected the key stakeholders as outlined in Table 2.1, an analysis of their power and contribution towards the learning environment was conducted. The results are illustrated in Table 2.2 below.

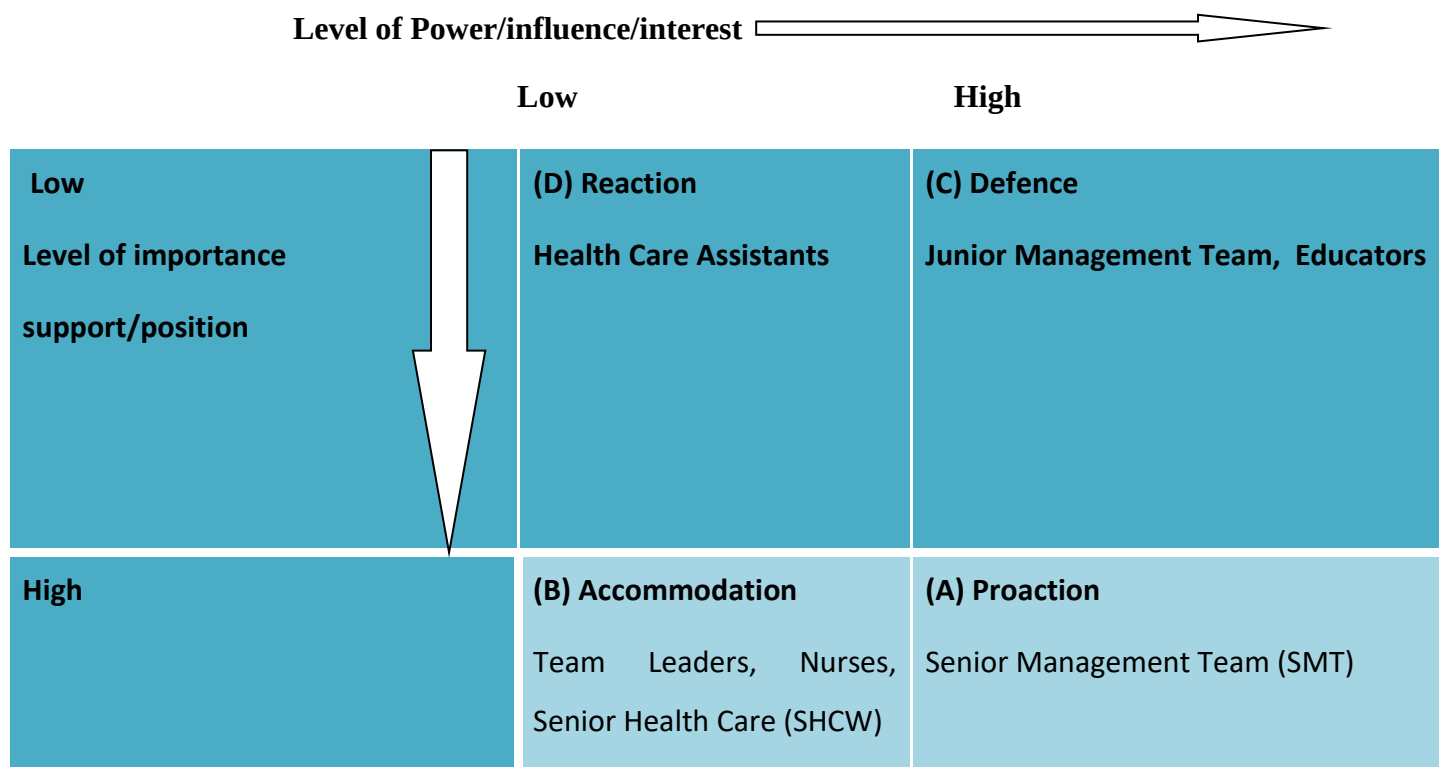


Table 2.2: Stakeholder contributions Source: created by Author (2019)

The stakeholders with the most power and highest position of influence were in group A in Table 2.2, which consists of the SMT. They were decision makers and project leaders responsible for most of the objectives determining the success of NH's learning environment. The SMT consisted of the directors of care, finance and HR, and the chief operating officer. The SMT was directly responsible for the strategy, implementation and evaluation of the process while also reporting to the organisation's board on any progress throughout the process. Group A stakeholders had to take proactive measures to ensure that the processes of learning and standards were being delivered and met.

Group B in Table 2.2 included the second-ranked stakeholders in terms of importance and support in creation of the learning environment. This group consisted of staff who were trained and developed to be assessors and were responsible for the supervision of other staff as well as monitoring of the day-to-day care practices in line with the education being delivered. Group C stakeholders had high power and influence as they supervised stakeholders in Group B, were responsible for the operational aspects of the care and took direct orders and feedback from the SMT in Group A. Their role was to ensure that standards and expectations defined by the SMT were being met, evaluated and escalated should any issues arise. Finally, Group D were mainly stakeholders who received education and support from all other stakeholders. However, their

experience of the learning environment determined how the care was delivered or practiced on a day-to-day basis; therefore they influenced outcome measures of the organisation's overall standards of care.

This stakeholder mapping was critical in that it supported the structure and decision to select the relevant methodology for data collection that would capture the experiences of each stakeholder group and be able to represent this in the findings, in view of the power, contribution and influence each had on learning within the organisation. Tailored sub-questions were utilised in the informal interviews to collect data from the different stakeholder groups. The selected stakeholders were mapped to identify those whose contribution had an impact and influence on learning at NH. Figure 3.1 outlines the four main categories of stakeholder, including their main role within the organisation.

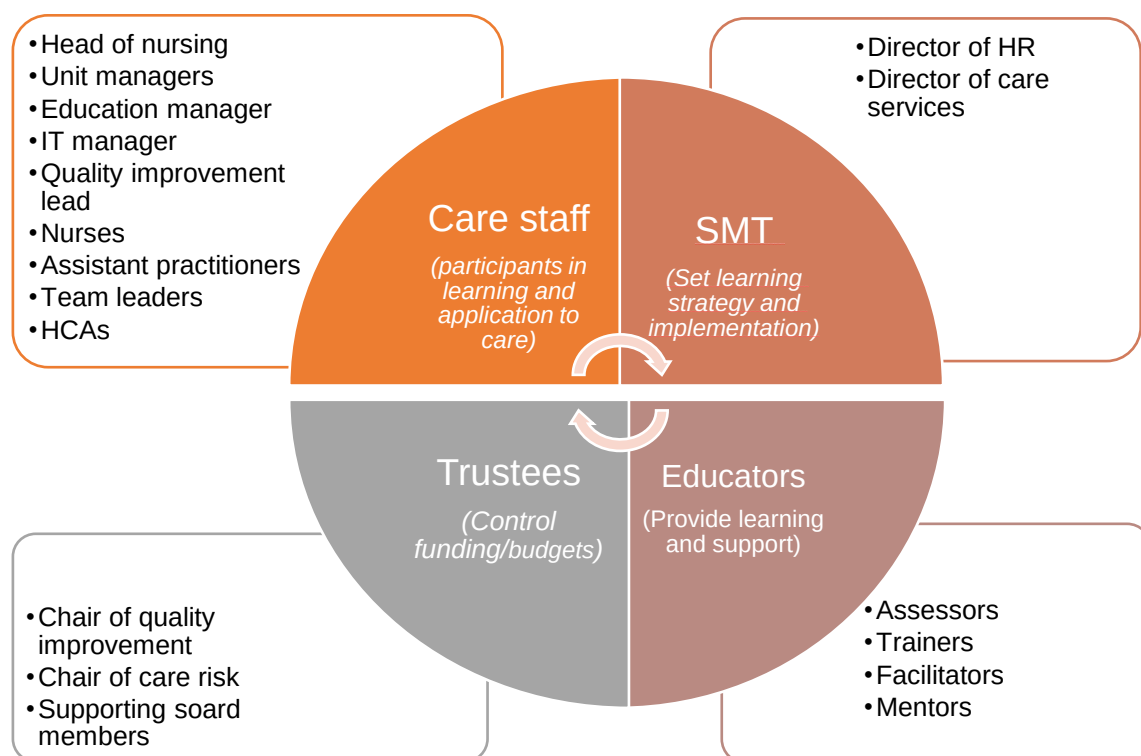


Figure 3.1: Stakeholder categories Source: created by Author (2020)

The reason for selection of interview (semi-structured) as a method for this research was to ensure that the information was of high quality as it would be provided directly by the participants. The literature review highlights that one of the best ways to collect qualitative data is via interviews; the data is generally reliable and the process offers a more in-depth gathering of information (Catterall, 2014). This echoes other researchers including Vaske

(2015), who states that interviews can also offer flexibility for the researcher to widely explore information provided as participants are available to explain and expand on it.

This approach removes the limitations experienced when using other methods such as questionnaires or surveys. The other reason for this method being chosen was that it offers a great degree of flexibility for participants to engage with me and provide any other relevant details that may have not been considered in questions directed to them. In the current study, this may be influential in understanding how the learning was applied in practice, for example. As this research also uses a case study strategy, informal interviews as a method of data collection best suits its intention to explore the organisation's culture and practices.

Semi-structured interview was chosen over a formal method to allow me to carefully consider predetermined questions. This was important to give the empirical evidence gathering process a focus, while guiding the interviewer and participants to explore the most specific and relevant data provided that would contribute to the research aims and objectives, and answer the questions. The advantage of the semi-structured interview method is that it allows participants to relax and engage with the researcher while sharing their own experience and views, which might be positive or negative. The literature review confirmed that for case study research, informal interviews reduce the level of anxiety, stress or withdrawal by the participant, relative to a formal and structured approach (Catterall, 2018). Open-ended questions were used to help the participants relax and talk freely, and simple prompts were used to keep the conversation in line with the research focus. Hand-written notes for each interview were recorded, focussing on specific key points the participants made. The notes and audio record captured specific quotes that could be cited in the findings.

3.5 Staging the Research

All initial processes involved in the research, including applying for and attaining ethics approval; producing a participant information sheet; contacting the care home provider about the research; and going through their internal due diligence checks before the proposal was accepted had to be completed within the 15-month period allowed for a DBA research project. These processes took around three months in total. The next step was engaging with the organisation to arrange data collection with participants, which took several weeks. In view of the time required to review and analyse the data to produce findings as part of the thesis, this left a research fieldwork period of around 8–10 months, which was considered sufficient. As

the pre-agreements around ethics and research proposals were accepted, the timetable in appendix 1 which illustrates how the project was structured with regard to time management.

The research timescale was easily managed as access to the organisation and data were straightforward. There was a clear research processes and systems that were easy to follow; and the organisation's attitude to research is very positive as they are already a patient participation centre.

3.6 Overview of the Fieldwork Procedure

Access to the organisation was organised through a proposal sent to the chief executive officer and subsequently discussed with the board, which approved the research. A letter of consent for this research to be conducted at NH was issued on 1 November 2019 (appendix 4). The agreement with the organisation was for research and sharing of information, findings, and particularly the wider recommendations to the rest of the industry. The organisation also allowed time for me to complete the stages of data collection, interviews and report writing as part of their current role, in line with the organisation's agenda to learn from research.

No particular issues were anticipated. The organisation had a very clear policy on research and I adhered to all procedures to ensure no problems were encountered. The organisation's Care Governance Board (CGB) also offered support to ensure everything went well. This was in the form of informal review meetings with one of the research specialist doctors who had an interest in the topic being explored.

Although the research did not include any vulnerable people, there was a risk of a participant disclosing sensitive information relating to safeguarding of vulnerable adults in the care home. The care home had its own clear policies and procedures for reporting and 'whistle-blowing', which I had to follow as part of the research agreement. This was explained to the participants so that they were aware of the duty of care that the researcher and participants had in this matter. The safeguarding lead within the organisation had to be informed of any issues raised so that proper procedures were followed to ensure the safety of the individuals concerned.

There were no risks to the process of primary and secondary data collection as the organisation had a clear research policy and process to support researchers. The only area for consideration was that I also worked for the organisation, although he was not responsible for the education and development of staff. Any findings to be shared with the organisation would be accepted

positively or negatively, which may have influenced future relationships as my employment continued till mid-2020. This was managed by ensuring that relevant staff and managers from the Education and Development team were fully briefed on the research question, aims, objectives and outcomes. My approach was to engage and build a positive relationship with Education and Development team before and during the process so that if there were any concerns, they felt comfortable to raise them and feel listened to. All concerns would be referred to the head of department or chief executive officer (depending on where concerns came from) consulted to assist if required.

To minimise the issues raised above, I implemented the following actions:

1. consulted with the board and chief executive before and after the research to establish clear expectations and processes for raising or addressing any issues
2. understanding of NH's research policy and process to ensure the design of methodology did not cause any conflict
3. joined the Network of Care Home Researchers (NoCHR), formed by doctoral students based in the care home to support researchers in the home in understanding how to conduct rigorous research and engage with staff
4. enrolled in the ethics training offered by the University of Surrey
5. Using pen and paper supported by a tape recorder for the interviews to ensure accuracy of factual information.

All participants were informed that the interviews would be anonymised; that is, the interview forms did not contain the names of participants and the interview questions were not designed to capture any identifiable information as they were general questions that sought participants' general views and feedback. The report and findings contain no details of who said what, but seek to ensure that comments are captured or referenced in a way that will not allow anyone to identify the source. The consent forms will remain securely stored in the office of the director of care services, which is secure as it complies with General Data Protection Regulations (GDPR) in relation to other research information stored securely therein. No staff have access to that office as it is securely locked and restricted to the chief executive officer, director of human resources (HR) and the director of care services.

The data will be retained only for the duration of the study, after which they will be handed over to the director of HR. The organisation has its own policies and procedures for data storage

and destruction; it uses confidential a waste system that means all documents are incinerated when no longer needed. The organisation also has a data protection guardian who is available to offer any advice in terms of the process of data handling.

3.7 Identifying Stakeholder Participants

The defined population for this research was care staff, both nurses and HCAs, working at NH; this excluded office, maintenance and other staff who were not directly involved in the day-to-day care of the residents. The sampling frame was therefore defined by just over 370 care staff working in the home. The sampling method selected for the research project was a non-probability approach, and more specifically, purposeful (judgmental). The reason for this choice of method was that the research question is examining standards for care across two categories of setting: residential and care homes. This meant the sample needed to include representatives from participants working in both areas.

Further, there are five categories of care applied in the care home industry, as defined in Chapter two within the literature review; any findings need to also reflect their application to each of those categories. While considering the sampling method to be used, I did consider other options, such as probability. However, Worthen (2014) states that the advantage of purposeful over probability sampling is that it is extremely time effective and requires few resources, making it cost effective. He adds that this method enriches qualitative research as it offers targeted and specific information relevant to the research area or question.

As this is qualitative research, purposeful sampling was used to obtain a sample size of 30 staff representing each of the five units that reflect both the five categories of care in the care home industry and relevant stakeholders at NH as mapped in table 2.1. The stakeholder research questions were divided into seven stakeholder group sections, into which participants were allocated based on their role and contribution to NH's learning environment as shown in appendix 3. These stakeholder group research questions were then used to create specific interview questionnaires for each of the seven participant groups. Appendix 6 to 12 (stakeholder interview questionnaires) illustrates how the interview questions for group 1 to 7 were designed to explore specific areas of practice or involvement of each participant group and the link to research aims and objectives of this DBA. Furthermore the questions are intended to compare stakeholder views to secondary data collected. The sampling approach used to achieve the intended data collection outcomes via the seven stakeholder research questions

(appendix 3), and based on the stakeholder mapping categories in Figure 3.1 is presented in Figure 3.2 (only illustrates the totals for each stakeholder in no particular hierarchy order).

Stakeholder group	No. of people interviewed	Percentage of people interviewed
<i>Care Governance Trustees</i>	1	25%
Care Managers	5	100%
Team Leaders	2	14%
Nurses	4	10%
Assistant Practitioners	3	21%
Educators	3	30%
Assessors	4	40%
Health Care Assistants	8	8%

Figure 3.2: Stakeholder sampling: Created by Author (2020)

3.8 Piloting

After designing the research questions for each stakeholder group and producing the participant information sheet, it was important to test this information for feasibility, clarity, readability and friendliness, and to determine whether relevant primary data could be captured as intended to address the questions to meet the research aims. First, I consulted with my DBA supervisor to obtain feedback on the interview forms, questions and design. He suggested reviewing the wording of some questions as they were not clearly linked to the research questions. This would have made it challenging to analyse the data and draw meaningful conclusions. However, his feedback was instrumental in mapping out interview questions to the right stakeholders based on their role and contributions to the learning environment.

Feedback of colleagues and other students completing the DBA programme was sought via workshops where the research aim, objectives and methods were presented, along with the stakeholder map and questions. They gave feedback on the questions and identified that questions intended for managers, who may participate in both roles of learning as well as delivering learning, should be kept separate to avoid biased feedback between their role as a learner or educator. The workshop feedback led to the a decision on a sampling process to identify managers responsible for quality assurance, educators, assessors and those going through their learning journey at NH. This would provide a wider perspective from different angles to enrich the data collected and when analysing the findings to deduce conclusions and recommendations.

Once the final version of questions was prepared, it was tested with volunteer participants. The target was around 10 test participants; to achieve this let to approaching the NoCHR associated with NH. This network was formed by a group of PhD students from the four universities that work with NH as a patient participation centre. The students come from different disciplines and are conducting research in the organisation on various topics including dementia care, medication management, ethics, spirituality, communication and handover. These topics are also relevant to standards of care in the organisation and linked to the education being provided by the organisation. Their involvement as test participants was considered to add value in the following ways:

- Provision of critical knowledge and research background to provide feedback on design and clarity of research questions in relation to the aims and objectives of the research
- Evaluation of the content and information available to the participants to ensure that it was adequate to support informed consent and identify any ethical issues.

The results from the pilot phase were positive as participants felt the questions were sufficiently simple and specific to explore the aims and objectives. They did however suggest that to ensure questions were appropriately allocated to participants based on their level of experience and role in the organisation, it would improve the quality of data capture to sort the interview guide so that it began with introductory questions as an ice breaker, followed by questions that were less direct and would keep the engaged but thinking about their own practice. Included in the feedback was a suggestion to include probing questions linked to the actual research questions, so that participants were encouraged to think critically about the specific subject being explored and their contribution, as opposed to their general perception. It was also suggested to include

some direct and indirect questions that would help participants to explore their knowledge beyond that entailed by their specific role. This was important as the learning environment in the organisation involves many multidisciplinary roles, responsibilities and interactions.

Colleagues in the organisation were also instrumental in providing feedback on the interview questions and format. Their suggestions were to include a question to explore what participants would have done differently. The rationale for this was that it would prompt participants to reflect on how the learning environment—or specific aspects of education, depending on which stakeholder was answering the question—would change. The value added from this question also ensured that the research was capturing what did not go well, as this would inform the recommendations from the research. The research outcomes were aimed to influence the industry; this would be achieved most effectively by being able to identify constraints, challenges and what did not work well, to identify the actions and interventions that would make the recommendations most applicable, cost effective and transformational.

This pilot stage of stakeholder feedback on the questions met my expectations in terms of the data collected. The selected stakeholders provided the following specific feedback:

- Definition of learning environment—The feedback was that a learning environment is one that provides training and CPD for all staff. All participants commented that they had access to learning through the learning platform and were able to attend face-to-face sessions as and when required.
- Exploring the characteristics of conceptual framework and how it was adopted—The participants involved in policy management and implementation commented that the organisation had developed a clear learning pathway for each staff group (nurses, care staff, managers, and specialists in dementia, pressure ulcers and falls). They also stated that the organisation's HR provides that education in terms of qualified trainers, assessors and subject experts within NH. They referred to the care governance system, which reviews education and monitors practice in reference to learning outcomes.
- Challenges and constraints faced by the home—Participants highlighted that it took a while to set up education resources and ensure that everyone fully understood the concept of delivering education in the new learning environment. Initially, turnover was the main issue as most staff had been developed to become educators before they moved, so the organisation felt the impact of having to train more staff.

- KPIs applied to effect improvements and how the role of learning was perceived by stakeholders—All participants were able to identify the KPI framework used at NH and link it to the CQC standards. They were also able to highlight where certain outcomes—such as complaints, turnover, incidents in safeguarding and disciplinary issues—had improved based on their experience in the different departments in which they worked.
- Lessons learnt in the past in relation to creating a learning environment—Feedback in this area was that the learning environment was very impactful in a positive way, although there was substantial culture shock because of the many changes happening in the culture of the organisation, including a quantitative compliance and training focus, and an educational and qualitative outcome focus. Initial feedback suggested that although most staff had come on board others simply could not fit in within the transformational process. This feedback was from staff who were responsible for performance management, who added that staff who left would at some point have had to be asked to leave in any case, because of their attitude to change. Participants talked about positive survey outcomes from staff and how gathering information to help evaluation of the project could have been improved by ensuring surveys were sent out in a timely manner to capture and reflect on initiatives within a reasonable time before people forgot or moved on to the next phase of the project. They also mentioned training more educators and assessors right from the start so that those resources were able to meet demand and not overstretched in capacity.
- Evaluation of whether the model can provide evidence of change in standards from ‘good’ to ‘outstanding’—There was an overwhelming positive response where test participants talked about their own experience of feeling motivated, empowered and confident in practice, as well as improved teamwork as everyone was proficiently practicing in an evidence-based manner.
- Make recommendations on how this could be disseminated across the industry—Feedback included that the research outcomes from this DBA should be published, as this is a new concept. It was also suggested that a manual or guide should be published with easy steps for how to replicate the process given that NH had spent several years developing and reviewing what works. Almost everyone suggested that NH should also become a centre of excellence where other people could come to learn.

Once the pilot was completed and all feedback was considered together with recommendations put in place, recruitment of study participants commenced.

3.9 Observing and Interviewing Informants

To ensure that adequate information was available to all staff to generate interest and facilitate informed consent for participation, the following steps were taken to raise awareness within the organisation:

- Meetings with department heads to introduce the research
- Workshop open to all staff to present the research aim, objectives and methodology, and to answer any questions
- Posted research posters around the home with key information about the contact person and stakeholders involved (London School of Commerce (LSC), University of Wales Trinity & Saint David [UWTSD])
- Made available patient participation information sheets including contact details of the researcher to facilitate expressions of interest
- Provided information and posters around the home for staff to access
- Included consent (appendix 5) forms with the participant information sheets so that expressions of interest could include a signed and dated consent form, which was collected before interview dates were set with the participant.

The research used all relevant tools to collect the necessary empirical evidence from the four main stakeholder categories outlined in Figure 3.1. This included formal and informal interviews as the main basis to gather qualitative data. Interviews explored each identified stakeholder's views, experiences and thoughts around the impact of learning within the organisation. The interviews also evaluated the organisation's systems, culture and practices that contribute to learning. To accurately capture the data from these interviews, audio recording was used with signed consent (appendix 5) from the participants. The use of digital audio recording is normal practice in the organisation, so all participants were familiar and comfortable with this method. All audio data were kept in a secure office within a locked drawer with access only to myself.

At least 90% of interviews were held in confidential meeting rooms located at NH, situated in Clapham South, London where all participants worked. Consideration was given to any special requirements such as visual or audio aids to support needs of staff in advance of the meetings, via pre-completed participant consent forms. The remaining 10% of interviews were conducted over the phone because of social distancing rules introduced following the COVID-19

outbreak. The same process was followed to ensure that participants were comfortable and provided with all information about the interviews and how the data would be used, with consideration of the fact that over the phone, it would have been impractical for me to see any visual cues stemming from how the participant is feeling. As all the questions were tailored to specific stakeholder groups, the risk of participants becoming stressed about the interview was minimal.

3.10 Interpreting, Reducing and Analysing Data

The method selected for the process was narrative analysis as this fits well with qualitative data collected via informal interviews and secondary sources. Wright et al. (2015) state that narrative data are spoken or written; however, it is essential when interpreting collected data to provide an in-depth understanding of the information acquired. They further explain that this will help the researcher to connect the different aspects of the data from participants or sources to map out trends, processes and relationships that enrich the quality of outcomes.

This was particularly important for this research project as secondary data were used to understand the background to the organisation's practice and processes, which would be compared with the informal interview feedback from participants.

The data were analysed using the following steps:

1. All interview notes were handwritten next to the printed questions and organised to link with the secondary data applicable to each participant, so that it could be viewed simultaneously.
2. The data were reviewed to identify trends and anomalies, and explore meanings.
3. Codes were created to map the data and establish key links to skills, knowledge and competencies, and to track how changes in care outcomes detected in the secondary data linked to informal interview data. For ease of reference, labels were used and notes written as data were being analysed.
4. The codes (labels) and notes were then reviewed to identify and define emerging themes.
5. A consolidated thesis was produced to summarise the linked themes and identify findings.

3.11 Appraising Epistemology and the Research Design

The case study and qualitative approach as part of epistemology method for this research was found to be the best approach for this type of research in view of the informal interview process for data collection and the secondary data used to compare with findings from the primary data. All interviews produced detailed information that had to be categorised according to specific stakeholder groups to ensure a methodical flow, and an analysis and reporting system that was clear and concise. This was only achievable through the story telling process. Further, the epistemological approach allowed the findings from interviews to be recorded factually without interpretation. The most powerful aspect of the epistemological approach is the ability to reflect direct quotations from participants to emphasise particular points that address some of the questions in the research design.

The research design was completed before the care industry was faced with the COVID-19 pandemic. Fortunately, the research was largely complete, with a few modifications such as the last four interviews conducted following social distancing rules. This required a change of venue in terms of interview rooms from the initially designated office into a larger meeting room, although all rooms were at NH. The research design proved to be easy to follow and effective in supporting data collection in both the primary and secondary phases. No challenges were experienced during the process apart from the COVID-19 implications on face to face interviews switching to telephone calls as most participants had no access to video conferencing facilities.

3.12 Ethical Issues

I considered that being an employee at NH presented a number of issues to consider from an ethics perspective. Therefore my efforts were to ensure that participants did not feel pressured to participate or provide information that they thought would please the researcher because of my affiliation within the organisation. To minimise this risk, as much information about the research, its aims and objectives were provided to staff via workshops. This afforded an opportunity to explain methods and intended outcomes of the research process, and to clarify my role as a student for this project. The organisation already had a research focus group established to evaluate research proposals and applications in the care home. Therefore involving the group in understanding the process of planning and communication to staff aided to identify any issues that may need to be considered in safeguarding the participants and

integrity of the research. The focus group was given the research questions as part of the pilot to evaluate and ensure they were safe and did not present any risk to the participants.

Further action to minimise risk to the participants, the organisation and its stakeholders included developing and communicating the following five principles to ensure ethical practice:

1. As the researcher I would ensure no harm is caused to any of the participants. This can be emotional, reputational or psychological harm. Safeguarding was discussed with the organisation's board to ensure that there were no other potential issues to consider.
2. Consent was obtained from the organisation's board of directors via the chief executive officer (appendix 4) who are responsible for approving all research projects in the organisation.
3. Ensuring complete confidentiality and anonymity of the data collected to protect the participants being mindful of the sensitivity between the employer and employee of data being collected as it relates to competencies, knowledge and skills.
4. Maintain integrity and trust at all times by being honest with all participants.
5. Each participant, including the organisation will be offered the right to withdraw from the process at any time. Any data relating to them will be destroyed as well upon request.

The organisation's chief executive officer signed off on the research project after considering all the risk factors that had been identified.

The main ethical issues considered in relation to the stakeholders involved were around IT, in terms of:

- **Digital data ownership.** The learning platforms used in the care home were licensed by a third party (external company) but hosted on a cloud system to which both the provider and NH had access. There was consideration in terms of what data the researcher needed, which stakeholders had access to them, whether they could be shared with other stakeholders, and whether additional access rights were needed from the third party provider of the licence. As the organisation had full access and authorisation rights, it was able to facilitate this should the need arise. The SMT was the main Caldecott guardian for data management in the organisation.

- **Privacy.** The information held regarding the learning progress of each staff member was private to the individual and organisation. Participants were informed that the researcher would access their learning information as part of the research, with their consent.
- **Data gathering.** The HR files and information were only accessed by HR personnel. Some of the secondary data needed was provided via HR staff who had authorised access to that information. Other stakeholders such as educators may also have held separate data about staff as part of their role in assessing competencies, and applying assessments and tests. I took every step to ensure that information was not shared among different stakeholders, but was kept confidential.
- **Security liability.** Data collected through interviews were kept safe (locked drawer in office) as they were mainly in digital audio (interviews) and paper form (secondary data). Any digital (typed) information were stored on the organisation's cloud system, which required a secure password for access and allocated access rights (I was given a secure online file to keep information).
- **Access costs. Being an employee at NH it was easy to gain authorised access** from the chief operating officer in relation to the research project, publication of findings and re-use of the information collected, there were no access issues or costs to the organisation.

3.13 Summary

The research method selected was designed to explore the questions for this DBA case study research using NH as the organisation of choice because of its size and structure, which provided a perfect research base representing care types within the industry. To collect appropriate primary and secondary data, it was considered that a qualitative approach in conjunction with semi-structured interviews with selected stakeholders was the best option. This would ensure that the research captured the experience and knowledge of staff in a factual way. A stakeholder mapping exercise identified four stakeholder categories consisting of staff and partners at NH who had direct influence, position and power in relation to the learning environment. Seven stakeholder group questions were designed to ensure that the most relevant questions were asked of the appropriate participants to collect facts aligned to the research questions.

Participants in this research were leaders and care staff (managers, trainers, nurses, assistant practitioners, senior health care workers, team leaders and HCAs, directors and trustees) who worked in or with the care home. The sampling method selected from NH staff for the research project was a non-probability approach; more specifically, purposeful (judgmental). Five care categories or types of care settings (nursing, residential, palliative, nursing with dementia and residential with dementia) in the care home industry. Any findings from this research project needed to be applicable to all five settings; hence, the sample size considered was 30 staff equally distributed across NH's five different households of resident clusters of which NH is divided into which represent the five categories of care within the care industry.

The epistemology approach was chosen to explore and present the findings from the primary data collected from stakeholders. This was considered the most efficient method to present the feedback from participants as factual and accurate, to reflect their views in relation to learning at NH. An interpretivist approach was used to gain understanding of what a learning environment at NH meant for the staff and how it had transformed their practice. This was critical as some of the feelings and reflections of participants had to be interpreted in the context of the research questions. The defined timeline was considered relevant for the sample size and the fact that access and permission to complete the research had already been approved by NH. Ethics training and approval following a detailed application process to the Ethics committee at UWTSD had been processed. Having accessed the code of practice for both NH and the university approving the study, to ensure my own competencies that would allow best practice and safeguarding of participants. There were no major risks identified since being very accustomed to the research policies, procedures and expectations of NH. There was, however, a general risk associated with confidentiality, privacy of data and participants raising concerns about the way in which the research was conducted, as well as the potential for a participant to disclose something during interview that constituted a safeguarding concern. The chapter has outlined clear and effective mitigating actions to prevent and manage any such potential risks. These were widely accepted by both the organisational and UWTSD ethics boards.

The piloting phase went well, after having shared the research questions and participant information with colleagues completing their DBA and others who were part of the research network at NH for their feedback. Positive responses were received along with recommendations for how to improve the questions to stimulate more reflections, which were taken into account before the actual interviews. The main research limitation identified was the

absence of similar research in the industry with which to compare findings or support the literature review. However, this is seen as an opportunity for further research to build on this DBA study.

Once the NH had given its consent for the research to take place, staff were informed of the research via their managers, whom I had already first consulted (after ethics approval was received from UWTSD). Participant information sheets were made available in the care home to raise awareness about the research and how to participate. This included a consent form that staff could complete and return directly to myself and safely stored to maintain confidentiality. Workshops in the care home were organised to share information about the research and answer any questions potential participants may have. This provided an opportunity and platform for interested staff to sign up. Once the intended participant number was reached, individual letters were sent to confirm interview dates, times and locations. Interviews were completed successfully.

Chapter 4: Findings

4.1 Introduction

The extensive data collection involved 30 interviews with a wide range of stakeholder groups from educators, learners, managers and trustees at NH. This resulted in a considerable quantity of data, leading to a variety of findings. This chapter records the views and opinions of the interviewees who represent all the stakeholder involved in education and care practices and echoes their voices as well as I am able to. The chapter begins with the nature of learning, the environment, how it was established and its impact on standards of care according to the views of the local stakeholders.

Hence, the chapter portrays the views of these participants clustered into categories of 7 stakeholder group questions based on their role and contribution to learning at NH. Although some of the 30 participants overlapped between the 7 groups, each group is asked specific questions using the stakeholder interview questionnaires from appendix 6 to 12. The aim was to explore the following critical areas linked to the research's aim and objectives as illustrated in appendix 3 as follows:

1. Definition of learning environment
2. Explore what characteristics of the conceptual framework and how this is adopted in practice?
3. What are common challenges and constraints faced by the care home?
4. KPI's used applied to affect improvements and how the role of learning is perceived by the stakeholders?
5. What lessons are learnt in the past in relation to NH creating a learning environment?
6. Evaluate whether this model can be evidenced to changes in standards from Good to Outstanding?
7. Make recommendations on how this could be disseminated across the industry

4.1.1 Stakeholder group 1: Definition of learning environment at NH

My first attempt was to understand how learning was defined at NH especially the type of modules, objectives, outcomes and structures involved. Furthermore to understand current practices in learning delivery to the whole workforce within the workplace environment. Therefore I used the interview questionnaire in appendix 6 to engage with the 14 participants in this group as categorised in appendix 3. The group consist of JMT, care staff and educators, at NH were asked to share their experience and understanding of what a learning environment means to them. I emphasised the subtle complexities of identifying the difference between training and learning. The first question was, ‘what is your understanding of a learning environment based on your time at NH?’ SMT responded that NH’s learning environment was defined by the facilities’ learning resource centre, library and learning platform. JMT expanded that NH’s infrastructure of education framework, culture policies and procedures in place to support staff to learn and develop skills and knowledge underpinned the environment for learning. The organisation’s Care Home Education vision focussed on ensuring equal opportunities for each employee to be exposed and experience education in a climate that was positive, encouraging, motivating and promoted reflective practice. One educator participant stated that:

from commencing employment, there are opportunities at every step and this is the first organisation that I have worked in which drives staff to do their best through supporting then to learn.

JMT specified that learning at NH included skills analysis, identifying development needs, goals, objectives and an improvement plan. One participant stated that ‘NH as a career and the education support I was given developed me to becoming a qualified assistant practitioner now’. The participant added that it was not only education that was provided: ‘the learning environment at NH provided coaching and mentorship which allows you to grow as you learn’. Another JMT participant shared that:

the best thing about NH’s learning environment is that it provides different learning and teaching approaches to accommodate for all learning styles. Further, there are test and ways to evaluate the learning so that staff can identify were they still need support to develop as opposed to just completing an education session and then being left.

Another added that:

The context and expectations within this environment is that supervisions are meant to guide growth in knowledge, competencies, skills and confidence to critically think and role model good care to other team members.

The educators stated that the learning environment at NH included the development and use of internal resources to create tailored education based on the demands and needs of residents, and this was all delivered in house.

This was supported by SMT who defined the components of learning to include mandatory training, induction, supervision, observation sessions, tests, formal qualifications through City & Guilds and other regulatory bodies, and peer training. They talked about the eLearning modules provided through the Altura learning platform and how this was structured in a way that ensured staff were assigned courses that were relevant to their role description, although they also had the opportunity to explore other subjects of personal interest. One SMT participant indicated that the best thing about the learning process at NH was that ‘the atmosphere encouraged reflective practice where an incident has happened’. The participant further expounded that there was a culture of openness that meant that when something went wrong, the manager or supervisors would sit down with the staff involved and have a discussion to review the incident, consider what caused it, what could have been done differently, and how to support the staff involved to prevent a similar incident in the future. This was supported by another SMT participant who said that ‘learning at NH was built on teaching values of the organisation and how to implement those in day-to-day practice when delivering care’. They both enlightened that NH’s values of compassion, respect, excellence, dignity, integrity and teamwork were integral to how the learning environment was developed as it changed the culture and atmosphere to one that was positive, supportive and conducive to improving performance while translating theory into practice.

Educators informed me that learning took place in all aspects of the organisation. They outlined that although there was structured learning conducted through workshops and teaching sessions in the learning zone (classroom setting with PowerPoint facilities and computers), much of the learning also took place in practice. They explicated this learning was facilitated by the educators and assessors who visited the resident households within NH where they worked and observed, assessed and interacted with staff as they delivered care. This part of learning they said was informal and more productive in the sense that it provided an opportunity for the staff to ask practical questions and be shown in practice how to execute a specific task, which built

their skills and confidence. All the participants in this group informed me that there was supporting learning material that they used in practice, which included workbooks designed to guide them through a learning experience to achieve certain learning objectives in practice. One educator detailed that the workbooks were linked to their induction, supervision and appraisal objectives to ensure consistency in monitoring and support for the learning process. Their feedback on this process of connecting the learning to a journey that was achievable and constructive was emphasised in a positive way that showed appreciation for how transformational the process had been. This was seconded by a JMT who said, 'I am so grateful for the learning process that it will take me all day to explain my experience'. This participant had begun their journey as a care assistant and had become a nursing assistant over their years at NH.

I asked in what way the learning environment had influenced their practice. All participants expressed overwhelming positivity and pride at having been part of the learning experience at NH. JMT and educators in particular quantified that their knowledge in elderly care, especially dementia, palliative and nursing care practices, had enormously improved. One educator participant stated that:

I have completely changed in a big way. More understanding of what you have learnt impact on how you do your job which changes the outcomes for the people you are looking after.

This was validated by another JMT who shared that learning had not only altered and improved the way in which they delivered care, but that they had started demonstrating to others and supporting them to learn just as they had. That participant stated that:

as a result, I was motivated to become a mentor to others and an educator because I am confident in the knowledge and skills I have which are evidence based.

One JMT emphasised that they had not only changed in their practice in care delivery but also in their attitude to work, saying that 'without the education I received at NH, I would have been just coming to work and doing this as a job and nothing more'.

The participant further expounded that they found a purpose and felt motivated to work towards a vision of excellence because they now felt so empowered. Participants proudly shared that they were more competent, knowledgeable, confident and positive in their roles. They described how their performance based on set objectives was now being achieved in practice

and how their attitude towards learning in practice had changed. JMT talked about the focus on PCC and placing the individual residents at the centre of everything they did through their understanding of the principles and research in this particular model of care. This notion was shared by another participant who stated that:

I feel that I have improved in so many ways. I initially this was just a job which I did out of the heart but following the learning environment introduced at NH, I now do the job well because of the knowledge and skills I have gained. We now understand the best approach to meet needs. We have been developed not just to be carers but much more in improving the quality of care for the residents.

Another educator was very positive about his experience of the learning environment and enlightened that:

the influence on my own practice is immeasurable. I have developed interpersonal skills and have become a better leader with better planning, communication and organising skills which have improved the care and support to my team.

This was echoed by another educator, who added that ‘education has changed me a lot and improved me as a leader and role model within my role as a manager’. They felt that this was important as it contributed to how their direct reports were developed and supported to demonstrate good practice, which led to better outcomes for residents. Another participant added that ‘due to the learning and development I have received, I feel that I am more efficient in doing my job’. They further expanded that managing teaching of care staff was challenging and yet relied on good leaders to make the right decisions that impacted on care outcomes. Having appropriate knowledge and competencies had allowed them to start thinking differently, apply new approaches and use their confidence in decision making, which allowed the rest of the team to focus on the things that had the most impact on care outcomes. This was supported by another JMT who believed that ‘when you practice in an environment where you are empowered to question and challenge things, and also be provided with the right answers, it improves your performance’. They explained that their practice had become shaped by the values in the organisation, which were instilled through the RCC education and model of care introduced by NH. They felt that the link between values, education and outcomes, which were measured for each staff member, helped them to change their team behaviour and attitudes, which contributed to better performance outcomes.

Some SMT participants highlighted the fact that changes in practice improved their teamwork and collaboration with Multidisciplinary Team (MDT) as they were now more knowledgeable and able to participate in care planning, case conferences and identifying care approaches to meet some of the complex care needs they came across on a day-to-day basis. One SMT stated that:

through the learning environment, it is easier to access any education or information while in practice. This allows me to raise discussions with my team members immediately to address practice changes or advise on the best outcomes. My knowledge and confidence in managing complex tissue viability cases and to determine what treatment options, types of dressings to use based on the grading of the wounds and approach to ensure that the pressure ulcer treatment plan meets best practice has improved so much.

The participant went on to elaborate on the importance of teamwork and communication in practice so that immediate action was taken to identify, diagnose and intervene before a resident's condition deteriorated. The participant explained that the learning environment created a culture in the home that empowered each team member to do this, hence improving the performance of the team and the outcomes for each resident. This was supported by another SMT participant who stated that:

the learning environment has influenced my practice in such a way that I see nursing from a different perspective. I now see the person rather than the disease or condition they have.

This participant was raising the point that before the learning environment and education she received, she would focus on clinical assessments and care plans for the resident based on nursing outcomes. There was no PCC approach in the care she delivered. The resident was not part of the clinical assessment and outcome. They were simply a recipient of the care, yet their priorities, wishes and goals may differ from what the nurses were focussing on. This created a situation of low satisfaction and led to complaints about care as the expectations of the nursing team and the resident or their family were not aligned. The participant also highlighted that the new focus within the learning environment was that care was driven by values and a focus on partnership and relationship building between the resident, staff and their relatives. The participant said that 'we are now a family which makes the quality of care and interactions even better'.

Most profound was the feedback from an educator who explained that the influence on their practice was:

bringing passion to the way I deliver care and improving my understanding of my duty of care. This gives me the motivation to do go the extra mile all the time.

When I asked this group what aspects of the learning environment participants felt had the most impact for the organisation, they identified ‘everything’ and how it was connected. There was a general consensus from all the SMT, JMT and educators that each element of the education, care approach and process of delivery complemented each other and provided a conducive environment for staff to connect with the vision of becoming a centre of excellence and having the tools and support to achieve that. Some participants were very detailed in their responses, highlighting different aspects of the learning environment. One JMT participant cited that PCC and RCC education and its application in practice were the major factors that was most influential in ‘creating a connection between the resident, staff and those involved in their care’. The participant felt that this connection enabled the staff to better understand the resident and treat them as an individual with respect and dignity. Another JMT supported this view and said they believe it empowered residents to feel part of the team and take ownership over the planning of their care and goals based on how they wanted them delivered. They experienced how it ultimately helped to manage expectations and reduce conflict or dissatisfaction caused by mismanaged expectations.

Another JMT participant said, ‘it’s hard to separate anything as the whole organisation changed’. However, the introduction of revised NH values in practice created more trust and teamwork within the work environment, which in turn improved the way everyone worked together towards the goal of demonstrating good practice. The participant further added that, ‘when the environment is fulfilling, staff deliver good results’. They explained that the way supervisions were now conducted—in a more coaching, supportive and positive way—created a platform for staff to reflect on practice, engage, feel listened to and supported, and develop into a team member who contributes high-value performance within the team. The outcome of this based on their experience was that there was overall low sickness levels and turnover. The point about organisational change was echoed by other SMT participants; for example, ‘organisational culture was the most impactful change’. They felt this was a result of opportunities offered to all staff to be developed, transparency in highlighting and addressing performance issues in a positive and supportive way and the availability of learning material

to build knowledge in a flexible way while working. The feedback centred on the fact that time was always an issue in delivering care; however, where staff were encouraged and empowered to do things differently to meet the designed outcomes. SMT participants told me this allowed them to exercise critical thinking and use their initiative to come up with certain solutions to the daily constraints and challenges they came across that place huge demands on time, resulting in care being affected. This was supported by a JMT participant, who added that:

learning environment resulted in a stress-free environment, which is positive and brought a spirit of togetherness. It brought the best out of me and made me feel valued, which in turn makes me want to do better.

This participant added that, 'teamwork was the biggest game changer and this came about because of all the changes in education, opportunities, values and culture'.

Educators highlighted introduction of the online learning platform, which provided access to many educational modules for staff. They felt that this provided easy access to learning material and policies for the organisation while in practice. They also stated that this platform provided freedom to learn 'on the go', and to decide what further development to take and at what point in time. The assessment and evaluation tests within these modules were commended for being well designed to meet the organisation's learning objectives and easy to manage without creating stress for staff. Educators informed me the platform was designed with different learning styles and levels in mind to meet everyone's needs hence its success. Aspects that other participants felt were important were the video and audio options of the modules available, as well as the hard copy learning materials.

Another aspect of the learning environment SMT and JMT participants told me had a strong impact was the formal education, which provided a career pathway for a number of the participants interviewed during the research. Staff talked about completing City & Guilds from Level 2–5. Some of the participants had completed advanced nurse practitioner courses that were joint delivered by NH in partnership with Croydon University and other partners such as St Christopher Hospice with funding provided by Health Education England. Several participants had commenced their nursing qualifications with Greenwich University to complete a two-year degree in adult nursing while NH provided their placement opportunity and some of the mentoring, coaching and funding. Educators added that working at NH provided career progression opportunities and as an employee they felt loyal to the organisation

and also wanted to give back what it had invested in them. They believed that commitment drive was the basis for staff staying on even though they could earn better salaries elsewhere. It was also why staff were committed to supporting the vision of the organisation at any cost.

JMT participants talked about the RCC education and model as key factors in the success of the learning environment and standards of care. They explained that the principals involved in the new model of care were based on team members valuing relationships with every individual person in their care. This involved the MDT, relatives and significant others of which when those relationships were functioning well, there was better collaboration and coordination of care towards the best outcomes. These JMT expressed that everyone involved started to contribute, fully knowing they were supported by people who shared the same vision regarding outcomes for the resident and the organisation. These participants highlighted that challenges in care are often complicated by poor communication and collaboration between the MDT, which RCC had addressed at NH, hence this RCC model has been impactful in addressing this issue with positive outcomes.

My last question for participants in stakeholder group 1 was whether they thought a learning environment had helped to improve the standards of care at NH. All participants said that it did. Their comments included:

oh yes. Most of the staff who come into care do not have the right knowledge, skills and competencies. Education provided at NH certainly shaped their attitudes and behaviours that led to the right outcomes on care.

and:

definitely yes, I have been at NH for the past 13 years and I can compare previously how care was. Things are certainly much better as we are upgraded in knowledge, performance hence better CQC outcomes.

Another participant said:

Oh yes, I have a lot to say but cannot put it all in words. Most of the staff have now completed their education and this has improved their skills, knowledge and translated this into practice. When I was a carer, I could see how my practice was compared to now when I am a qualified AP [Assistant Practitioner]. I can also now see new staff being developed from day one of starting at NH to become proficient in their practice.

Another participant shared that:

oh without a shadow of doubt, definitely. PCC has improved tremendously and since being here for more than 30 years and I see a huge difference in staff and feel that NH is an amazing place.

The general consensus was that as the organisation was now demonstrating its values in practice with everyone empowered to understand how they could contribute to the broader vision through new skills and competencies, standards of care had definitely improved. One participant explained that, ‘when you fully understand what the care standards are and how to achieve them, it becomes easier to work towards them’.

4.1.2 Stakeholder group 2: What are the characteristics of the conceptual framework and how this was adopted in practice?

My second focus was to understand how the conceptual framework of learning environment was designed and adopted in practice. I therefore used appendix 7 questionnaire to interview stakeholder group 2 consist of senior management team (SMT) and junior management team (JMT) including educators who participated in the education governance system at NH. I believe their influence and contribution to the setting up of the educational policies and procedures that underpinned the whole learning environment. This group is responsible for some of the quality assurance related to education standards within NH. The first question I asked was designed to establish what educational policies and procedures were in place. SMT participants described how NH’s framework of Care Home Education Centre (CHEC) was built on an induction policy that covered common induction standards established by the CQC and Skills for Care. This was supported by JMT who explained this policy was designed to support and induct new team members who were new into care to complete their Level 2, which is a formally accredited qualification with City & Guilds. SMT concurred with them that aims and objectives of this policy was to ensure critical aspects of PCC, dignity, health and safety and some of the fundamental standards of care expected by the CQC were achieved through education from start of employment.

This group of participants highlighted the importance of NH’s induction policy linking to the probationary policy for all new staff who joined the organisation. Educators outlined that induction policy sets out that bi-monthly supervisions should be conducted with each new staff member over the first six months of employment to assess progress and ensure the right

education support is provided to the new staff according to NH's expectations. In agreement, JMT further expanded that aims and objectives of probationary supervision were to assess the skills, knowledge and competencies of new staff, identify any gaps in line with their role description and provide the necessary support through education, coaching and mentoring. They outlined that the first six months was the period in which the organisation established targets and outcomes that staff members should demonstrate within their role to be confirmed in full employment. SMT stated to me this was a way of ensuring that when a new staff member was confirmed into a role, they were fully competent to deliver the right care at an appropriate standard as defined by NH. Some of the education provided within this period as defined by the policy included online courses, face-to-face assessments, workshop attendance and shadowing other senior staff members to learn through observation. Educators articulated to me that this was critical in ensuring that staff's contracts are only confirmed when they demonstrate successful completion of induction and probation. Which they believe led to only the right people staying in the organisation and reducing turnover in future.

This group of participants also conversed about the supervision policy that covered every employee in the organisation. They explained that it set out that supervision support meetings were held every two months with the managers allocated to the respective staff members. Educators outlined that each supervision had objectives that were set, reviewed and used to assess the progress and development of each staff member. They also highlighted that the policy intends supervision as an opportunity for staff to engage with their manager and determine their personal development plan in line with the organisation's vision, mission and needs. One JMT participant described how 'my supervision is a platform for me and my manager to evaluate learning and progress while considering what other opportunities are available to support my growth'. Other educator participants identified the link between supervision and performance management and capability policies and explained that if there were issues with a staff member not meeting their targets continuously, these policies were available to involve the person in a probationary process where they were given a chance to improve their performance and demonstrate that they could perform the required role effectively and deliver on the expected outcomes.

JMT's feedback was that this was done in a positive way and managed so that staff who were underperforming did not end up causing the whole team to fail in delivering NH standards of care if left unmanaged. I was informed that other policies such as equality and diversity were

used within NH to ensure that all staff went through a fair process of support and had access to learning material from commencing employment at NH until they left for any reason. SMT expanded that as NH employed around 350 staff in different roles, the equality and diversity policy also ensured that each person was treated fairly so that appropriate steps to assess and identify learning gaps, and provision of individualised learning plans and opportunities were developed and reviewed in the same way for everyone, regardless of hierarchy or role within the organisation.

This participant group were also asked to explain who led the education programmes within the organisation to establish how the system was run and governed. SMT outlined that the director of care services was the lead for the CHEC and was the registered principle provider with City & Guilds. They expanded that this role covered both clinical practice, education and development, which provided a link between care demands and provision of support or resources to meet those demands through education. JMT added that the director of HR being the lead of the Educational and Development Governance Steering Group set up in NH to monitor, advice on and evaluate learning standards. SMT further highlighted the terms of reference for this role and the governance committee as one where all the decisions regarding the education to be provided at different levels and the funding support required were made before being referred to the NH main board of directors for a final decision. The steering group consisted of educators, assessors, mentors, managers, directors and representatives from the HR team. Participants described its composition (members) as an effective representation of all areas of the business that was responsible for ensuring the implementation and success of a learning environment.

I asked all participants to expand on the governance of education and how the education steering group quality assured induction, supervision, appraisal, accidents and incidents. Furthermore how they analysed trends in reference to the education being provided and the impact it was having on reportable incidences. Educators informed me that the steering group met quarterly with the educators, learners, JMT and SMT representatives and discussed KPI progress and proposed action plans for both education and incident reports whilst comparing outcomes between them. SMT confirmed that the steering group then made recommendations and reported its findings to the Care Governance Board (CGB) which assessed if the action plans were suitable and sufficient to meet the areas of improvement required based on the trends analysis. I was informed by JMT of the value that the CGB had in overseeing practice

within the home and reporting all action plans and outcomes to the main board of directors led by the Chairman of NH. All participants indicated that this culture and level of transparency assured that change was effective and consistent across the organisation whilst ensuring the right standards of care are being sustained.

As part of the governance system involved evaluating the impact of the education and resources provided based on what SMT shared with me, I asked them to explain further how and who was involved in this process. Their feedback was that the impact of education was evaluated mainly through the education and development manager and HR team, who were responsible for the KPIs for the learning environment illustrated in appendix 2. This KPI evaluation system is conducted through a traffic light system that identified areas being met as green, areas for improvement in yellow and areas of concern in amber. SMT indicated that this was a useful way to track progress and achievements in a way that visually enabled all stakeholders to understand the areas on which to focus at a glance. They explained that the education and development manager worked closely with department heads and managers to ensure that there was collaboration in auditing and consolidation of all the outcomes into the KPI monitoring system. Other committees in the organisation participated in the evaluation process, as described by participants who talked about the HR department, which produced assessments, quizzes, tests and performance reports from the online learning zone where staff completed their educational courses. According to one SMT participant:

this information was fed into the governance reports and provided an overview of how impactful education was based on the results of testing staff's understanding as well as comparing this to practice audits such as falls, incidents, complaints and safeguarding concerns.

As stakeholder group 2 members were also involved in the design of the learning environment, I asked for their insight on who provided the education and what qualifications they had to do this. Feedback from educators was that educators had completed formal training in Preparing to Teach in the Lifelong Learning Sector, now called Level 3 AET. They explained that other educators had completed the Level 3 certificate and award in Assessing Vocational Achievement. All participants said they valued the approach of developing and using qualified educators in the organisation as it ensured that all the education being delivered was directly linked to NH's policies, procedures, vision, mission and standards. SMT explained how previously the process included outsourcing training but this was always found to be too

generic, not tailored to the care needs at NH and difficult to quality assure. One participant added that:

having in-house educators is an advantage as they also form a part of the leadership team who are monitoring trends quality assurance and know what is going on at operational level.

Educators agreed with this and added that this formed part of quality assurance as they also sat on the various governance boards in the organisation and were thus able to give direct feedback regarding their observations and make relevant recommendations to improve outcomes relative to when the organisation relied on outside providers. Another participant discussed that subject experts in the organisation were used to deliver certain specialist or clinical education sessions. It was reported that:

we have specialist nurses who are qualified in infection control, tissue viability, EoLC and many other specific areas. They provide education in their fields of expertise and this works well as they are also able to take the staff through practical competencies to ensure that the knowledge imparted is translated into practice.

SMT concurred and further explained that this gave NH a competitive advantage over other providers in the sense that education was delivered in a consistent, tailored and outcome-based format compared with other homes.

JMT talked about NH's partnerships with Kings College, City, Surrey, Croydon and Kingstone universities to conduct research and share subject expert resources. They mentioned that staff would be offered the opportunity to attend courses at these universities and that students from these universities would come to NH and work with staff as part of placement or research. SMT concurred that this had proved to provide another education platform where information was cross-fertilised between the two groups in a practical setting.

I asked this stakeholder group to comment on how practice was linked to education as part of the learning environment. One JMT participant was very emphatic, saying 'no education, no practice'. They explained that as NH had moved away from training and was now focussing on education defined by learning, attaining knowledge, skills and competencies, their learning objectives delivered through education were designed form practice outcomes that NH wanted all staff to demonstrate. The participant went on to say that:

education is integrated into practice through competency assessment in work which staff have to complete and demonstrate that they can now deliver what they have learnt after the online sessions or attending any workshop.

Further comments from educators included the fact that the availability of internal assessors made it possible to follow up on staff members who had completed education and then set up observations in practice. Another educator suggested that NH's learning environment resulted in 'learning on the go'. This was a comment in connection with the availability of learning material on the hand-held devices that all staff carry for their daily notes and care plans as staff could now access policies, procedures and video clips on how to complete a certain task while delivering care. JMT added that staff handover and meetings processes had since been remodelled so that they were a platform for reflective discussions and learning while in practice. One participant talked about short topic discussions such as tool box sessions on any particular subject that may have followed an incident, audit trends or something new like policies or procedures which staff needed to be aware. Another JMT participant added that education was now linked to practice through the learning CHEC framework using case study or case scenarios involving practical and actual events relevant to the workplace, so that team members could connect with the reflection discussions and learning outcomes being addressed.

4.1.3 Stakeholder group 3: Common challenges and constraints faced by NH

To understand what challenges and constraints the organisation faced developing and implementing their learning environment, I used appendix 8 (stakeholder interview questionnaire) to explore this group's' experience and views as they were involved in operations, finances and resource decision making as part of their role. This group consist of different JMT, SMT and educators and the first theme evident from their feedback was the aspect of cultural change. SMT all cited culture change at organisational, management and operational level being hard to transform from task and compliance approach to PCC and RCC. One participant suggested that the challenge with 'culture at organisational level was concerned with the NH operating in a compliance system within the industry'. They went further to explain that this may have been historically driven by CQC's approach to inspections which were very task focussed in what evidence they expected to show how NH was meeting its standards. This is believed by SMT to have overtime generated a leadership focus on only those aspects they knew would contribute to NH's performance. SMT stated they used to be concerned about the penalties for non-compliance which could result in a business losing its

market position and competitive advantage, as marketing for residents was based on favourable CQC ratings. To that effect, they tended to focus only on the areas likely to be inspected by CQC. They suggested this meant that there was no incentive or investment appetite for doing something extra that may not be part of CQC's inspection focus, hence a reluctance to do things differently at first.

JMT and educators confirmed this, with one participant highlighting that NH's leadership culture changed when it reviewed its organisational values according to them "which challenged individual practice and why we do what we do". They outlined that one of the values 'excellence became the focus outcome for everything we did instead of CQC inspections especially around workforce development outcomes'. This is believed to have changed the culture from just compliance with CQC training requirements to 'now based on personal development of each staff'. This was echoed by another JMT participant who added that 'the main challenge was to create the right resources and atmosphere which promoted learning and not just training'. Another added that 'the push to move enough financial resources to create the right resources was initially a big challenge that was overcome'. These comments were in relation to the fact that NH had to fundraise for extra resources and use some of its budget to create more posts for educators, assessors and qualified subject experts who would form part of the education team to deliver learning across the whole organisation.

One educator suggested that the culture of the team and departments also had to change in terms of adopting the new way of delivering education and learning, which initially was unfamiliar to staff, particularly those who had been working at NH for a long time. Their initial attitude to the change was filled with anxiety and uncertainty because of fear of being under pressure to complete courses. Feedback from the participants was that NH had to respond by identifying extra support and time for staff who had special needs such as IT, literacy and other learning challenges. One JMT said, 'it was challenging to develop the education strategy, learning guides and outcomes to make them specific to what staff needed to know due to low literacy levels. The participant went on to further explain that around 60% of staff did not use English as their first language and this meant that each course had to be evaluated in advance to ensure that staff would not struggle to understand and thus lose interest.

SMT participants shared that NH met with the chosen eLearning platform providers to consider any changes to the content being provided and that NH had full control, enabling it to adjust, rewrite and customise the learning material on the platform. Educators stated once this was

mapped out and communicated to the rest of the organisation to reassure all staff and the first staff had completed their education, this shifted everyone's attitudes: they began to realise they could accomplish the same outcomes. Another point raised through the interviews was there was change in leadership culture in that managers had to shift their approach, attitude and behaviour from a procedural and task-oriented focus when completing inductions, supervisions and appraisals from a directive short-term task focus to a CPD, coaching and mentoring approach to facilitate developmental learning. JMT added that leadership and mentorship short courses and workshops attended by managers to support their skills and competencies to adopt a new style of managing their own staff were extremely beneficial although challenging to complete due to time constraints at first.

Another significant point raised by this group of participants was that it was challenging to come up with a philosophy, model and framework for the learning environment modelled as CHEC, as this was a completely new concept in which no one was experienced. They explained that as new ideas were being introduced, staff were initially weary regarding whether this would work in practice. SMT said they had to put extra effort in conducting numerous workshops to share information and research. As this was a huge shift in culture and practice, they had to reassure staff and include them in the planning phases as part of consultation to ensure that everyone understood the vision and how this could be achieved. Educators agreed with this and further highlighted that this process initially placed strain on the leadership team as it had to progress this vision while ensuring NH was delivering care to the highest standard. Although some participants reported that support was made available through the volunteering department—where more specific volunteers were introduced to support certain administration and research tasks—there was still an element of stress experienced by the leadership team responsible for delivering the objectives of this innovative approach.

Notwithstanding the challenges outlined during the interviews, I asked this group of participants to reflect on how easy it was to establish the learning environment once those initial challenges were addressed. My intentions was to assess whether there are areas which could be considered as easy starting steps should this research indicate positive impact on standards of care and other care homes want to go through the same journey. Feedback varied as some educators responded that 'it was not easy as they had to be educated themselves and reach certain competency level to be confident to deliver education to others'. Some suggested that 'it was difficult as staff were not used to speaking about things and sharing practice or

experience'. JMT concurred with this reflection from educators and explained that they too had to be confident in their own practice to talk and share their experience as part of reflective learning. They added that as the learning process started to develop, gaps in skills and knowledge between staff became evident as each team progressed at different levels and speeds resulting in some tensions. This was addressed by setting up learning platforms including different teams to create a cross-fertilisation experience and a platform for staff to engage, learn from each other and narrow practice gaps. SMT however highlight that once this process was in motion, the learning environment process became much easier as staff became excited and passionate when they started learning new information and skills that they wanted to share with others. Another participant explained that:

once staff understood the reason for change and the benefit to them for creating this learning environment that gave them a good reason to want to contribute to that change.

When I asked all participants to reflect on what did not work so well in order to consider areas for other care homes to be aware of should this research be shared across with other providers. This group of participants agreed on the integration between the old system of delivering training and the new approach of learning through education and practice development. SMT explained to me that within the industry, governing bodies such as CQC, Health Education England and the Skills for Care were still focussing on compliance with specific mandatory training outcomes. Which have to be evidenced in a particular way; for example, staff must have attended a training session under the label of 'health and safety' although this does not fit into the new learning framework now used by NH. Educators informed me that the learning approach at NH is designed to develop staff understanding through continuous education steps, which meant that staff learnt about assessing, supporting and mitigating risk to residents. It develops staff's understanding in each aspect of legislation and requires them to provide evidence of good practice through numerous activities and exercises before being signed off as completed the health and safety training. Educators were concerned to achieve this, the process will take more than one hour as opposed to industry practice and minimum training requirements CQC and other regulators expect and consider as suitably sufficient. JMT agreed to evidence the new NH way of education to CQC became a challenge if the inspector was looking for evidence of a specific health and safety hour training session delivered to staff as part of compliance on an annual basis. Nevertheless, participants highlighted that to overcome this, they retained compliance core sessions to meet CQC requirements and recorded

attendance at the point of completing the theory sessions whilst still supporting staff to progress with the rest of the modules beyond just the theory.

SMT indicated that collaboration with the wider health care community did not go well and made the learning environment implementation challenging. They explained that ‘unfortunately care homes are isolated units within the health care industry and no one listens to them when it came to investment from the Department of Health (DoH), National Health Service (NHS) or local authority government’. This comment was made in reference to the idea that there was no interest from either of these government organisations to support change from compliance inspections. Nor to provide funding or share resources that could make the process of implementing a learning environment easy by creating opportunities for joint education resources (educators, assessors or subject experts) to go into the care home to deliver sessions. JMT agreed and expressed how later in the project collaborations between NH and NHS services started to develop through geriatric, ophthalmology and dietician services started to support education in the care home to positively improve polypharmacy and deep prescribing. Although partnerships had been formed with local clinical commissioning groups where NH is geographically based, SMT and JMT both agreed a more inclusive approach could be better for sustainability of education for nurses and practitioners in the home if the local authority and the Department of Health and Social Care were more interested in supporting education in the care home.

Educators shared another area considered not to have worked well at the beginning of the learning environment process was use of eLearning. Educators further explained this was a new concept to many staff and thus some were still struggling to conceptualise what they were learning and try to put it in practice. Although support was later made effectively available at the end point of education assessments, it did take longer for staff struggling with literacy and confidence in attending online sessions. JMT said they had suggested to assess learning difficulties and provide adapted learning pathways to suit individuals likely to struggle after the initial review of the project. One participant highlighted whilst this improved the situation, there were still operational issues with staff missing sessions and not wanting to engage. Educators felt that the eLearning process on its own was perhaps less interactive at the beginning and thus some staff who were generally not motivated or interested in learning had become laid back and did not change their practice as they were learning little. This was supported by comment from another SMT participant, that initially staff who did not want to

learn more than they used to but rather only did the bare minimum to pass the module. However, they also added that overtime as staff became confident in the use of eLearning they began to take more self-initiated interest. Nevertheless, educators felt this could have been improved had the skills assessments been completed from the onset with appropriate help made available.

Other feedback from this group was that from a leadership perspective, ‘consistency in learning is affected by priorities to deliver care where dependency on certain education courses is on certain subject experts to manage the learning programmes ’as expressed by one participant. JMT, however, went on to explain that they had begun trying to develop more subject experts and reviewing the allocation of education to spread the responsibilities to other people with potential. SMT explained that supervision was an opportunity to assess and identify potential educators. Supervision required having specific objectives, identifying constraints and setting realistic and achievable goals that could help the organisation to meet their demand for resources to sustain the learning environment. This comment was made with reference to the need to identify and explore new talent and not rely on current subject experts or resources that were likely to be overstretched as they also had managing responsibilities for day-to-day running of the home.

I also asked to reflect on staff responses when everything was well established and the learning environment was created at NH. Statements from the participants included, ‘everyone was excited, the team is positively competitive were as before some of the senior staff used to be reluctant to do anything and had a lot of excuse’ and ‘staff were optimistic about their future as HCAs benefitted more because they did not have a career pathway as nurses did’. Both JMT and Educators agreed that staff were happy and felt that they were being supported to achieve more; it was said that ‘staff felt that they were working in a safe environment where they felt support was available if there were knowledge gaps in practice’. SMT added this attributed to easy access to learning material, education resources and assessor availability in the home to review progress and identify any further support needed. Participants also shared that while most staff were excited and enthusiastic—despite having initially been reserved or sceptical about the change in impact on them—most now felt proud to be part of an initiative that had brought success and established NH as a pioneering beacon in the industry.

Through the interview I sought to explore any negative aspects of creating the learning environment. Most participants responded that there were no negative aspects and that it was

the best thing that had happened in terms of transforming the organisation and how it performed. SMT commented on the governance structure and membership and outlined that the only negative aspect was that as a result of the shift in the organisation's culture and vision to create the learning environment, some governance members who had been there for a long time left as they could not appreciate the new vision. JMT concurred stating that although these departing members had been very supportive of the organisation, in itself their departure was not so negative in the long run as it created opportunities for other members to join and bring fresh ideas that improved the project implementation and sustainability. Educators added that in the initial stages of the learning environment, there were divisions between staff who had embraced the vision and new way of practice in the learning environment and those who had not. This was reported to have balanced out over time with more support and encouragement for those staff who may have been struggling and feeling threatened by the change.

The final question I posed to stakeholder group 3 was how they and the organisation dealt with the challenges faced. The key information they shared was that, the most important aspect of creating a learning environment was creating a culture of inclusivity, valuing each person regardless of how challenging were their views or approach and encouraging self-esteem and making staff feel they were part of an important 'bigger picture'. JMT participants cited that developing partnerships with other professionals from the universities with which NH had established links was very helpful as it provided subject expertise in how to support adult learning and identify the most effective way to structure learning objectives and outcomes in practice. Along the same lines, educators also talked about the value of inviting guest speakers to workshops and how this brought fresh ideas that rejuvenated the team and improved ideas and plans for the learning environment at NH. JMT and educators said that creating the Education and Development Steering Group that included some of the external subject experts also helped to validate the approach that the organisation was taking and this made staff feel confident in the outcomes and recommendations being made in terms of new policies, structures and systems being developed and introduced to facilitate learning (as mentioned by stakeholder Group 2).

One other area that all participants felt had made a significant difference to the challenges of trying to encourage learning for all staff was the introduction of the eLearning platform and the learning zone that allowed staff to have flexible learning and access to resources while at work and at home. SMT highlighted the linking of learning objectives with inductions,

supervisions, appraisals and reflective meetings as one way that made an impact when addressing culture and competencies of team members. One participant said:

mapping the knowledge and competency gaps of each staff, identifying their areas of strength and weaknesses then working with them individually to create an improvement and support plan that was for the whole year with clear objectives and assigned courses to attend enabled staff to see the vision of how they can improve and contribute towards the organisation's vision over the course of their continuous development plan.

Educators also acknowledged the introduction of incentives and celebration of achievement events, which had created a sense of validation for those who were meeting targets. They stated that NH introduced an annual award event at which staff who had completed their courses or made any significant contributions to research or furthering the vision were acknowledged and presented with certificates as part of a graduation ceremony; as well as tokens of thanks that included vouchers, flowers and small gifts. SMT feedback that the organisation's approach in investing allocated time for learning (25 hours per year as a minimum) and not forcing staff to complete all available courses made it easy for staff to wanted to learn, as opposed to feeling obligated to learn. Positive attitudes were created, as one participant said, by:

making the vision clear and achievable to staff, which made staff realise they were part of something that was bigger than them and it motivated them to participate in the bigger picture.

4.1.4 Stakeholder group 4: Key performance indicators applied to bring improvement, and the role of learning as perceived by stakeholders

This stakeholder group consisted of leadership and governance team members from different SMT, JMT and educators who some were team leaders and care managers. The questions I asked using appendix 9 (stakeholder interview questionnaire) were focussed on establishing what KPIs had been used to bring about improvements and how the role of learning was perceived by these stakeholders. The purpose of this question in reference to the main research question for this DBA was to explore the quality assurance framework for the learning environment; identify how trends and reporting cycles enabled improvements; and identify the KPIs that related to learning environment outcomes and standards of care. The first sub-questions I asked to explore the main question was, 'which of NH's standards of care were used to measure practice improvement'? The stakeholder feedback identified the following:

1. The CQC's 16 fundamental standards of care as outlined in the KLOEs. These were used to identify how the organisation ensured it was compliant with its legal and registration expectations; and to demonstrate that they could evidence practice in those areas. The CQC standards were not the entire primary focus, as NH aspired to its own standards of excellence.
2. The International Dysphagia Diet Standardisation Initiatives. Participants stated that due to frailty and multiple comorbidities among residents at NH, malnutrition, dehydration and weight loss affected 85% of the residents. This was also an area that connected to other aspects of medical and clinical care such as pressure ulcers, falls and delirium, which are common in elderly people yet preventable if nutrition and hydration standards are met for each resident.
3. NH Care Governance Standards. Participants outlined that NH had developed its own KPIs based on aspects of practice they wanted to see improve following the introduction of the learning environment and the focus on excellence. They described the categories of standards illustrated in Figure 4.1.

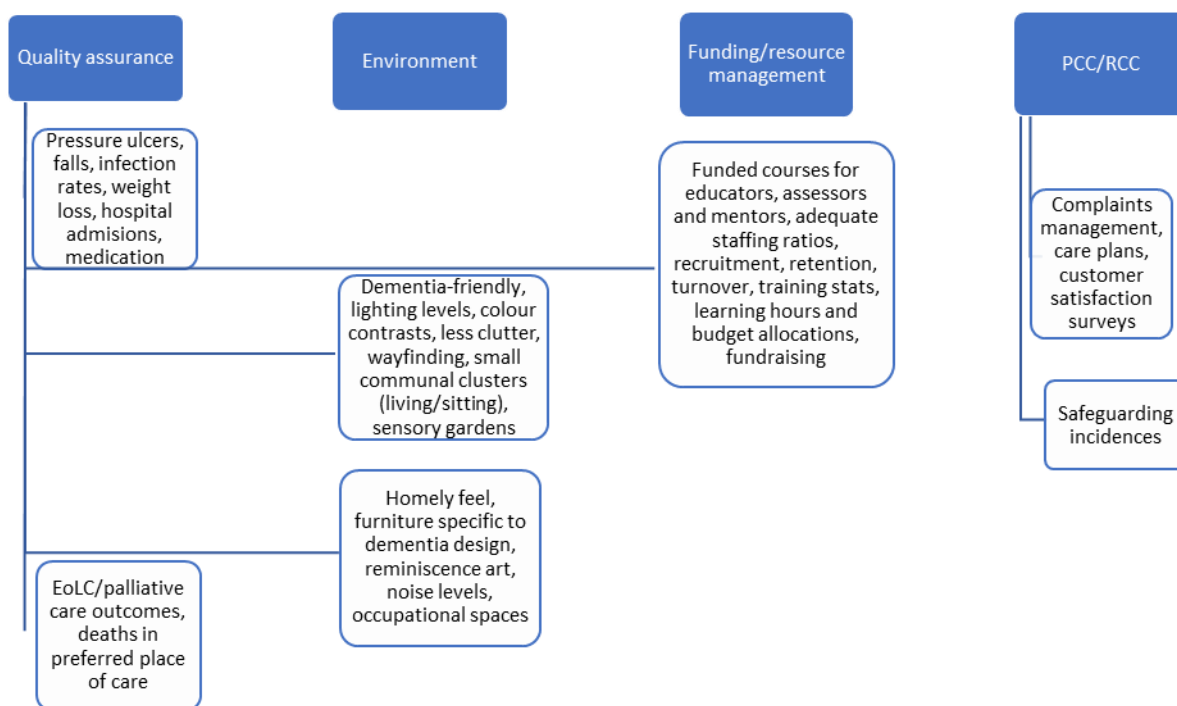


Figure 4.1: Governance standards Source: NH five-year strategic plan (2019)

JMT' explained that these KPIs were audited on a weekly basis by the lead nurses in each of the five households into which NH was divided. The audit results were forwarded to the quality improvement lead whose responsibility was to complete a trends analysis and follow up on

each area of concern with the relevant household manager or the nursing team in charge. Educators also confirmed that weekly audits were entered into a central reporting system for the Care Governance Group that met every three months to review trends and action plans in place, and make any recommendations. This was elaborated by SMT who added that outcomes of the governance review were directed to NH's Audit and Risk Committee, which was in charge of all risks in the organisation. They highlighted that to make the process effective, areas of improvement that posed a risk to the organisation were entered into its Care Risk Register and forwarded to the main board of directors, which also met every three months. Both SMT and JMT stated that the risk areas escalated to the care governance and risk committees may differ depending on the type of admission; for example, admission of more frail residents under emergency could result in additional clinical risks such as pressure ulcers. They said admissions or cycles of care such as during the flu season resulted in more chest infections contributing to falls. One JMT participant explained that:

KPIs were set against standards of care and key risk areas that relate to elderly care. NH uses a traffic light system (red, amber, and green for low risk) to track and review each risk that is identified. This information is also shared with all the team members so they know exactly what areas need to be improved much earlier at amber before they are in red.

All participants agreed that pressure ulcers, falls, hospital admissions, incidents and safeguarding were the areas that were most often referred to the Care Governance Board and further reviewed by the Audit and Risk Committee. SMT rationalised that as these were the top priority KPIs providing a clearer picture of the performance of NH in terms of care delivery standards. Additionally, educators said that EoLC was the most important focus, reflecting the high average age of admission and that most people coming into care were frail and in their last days of life. They commented that NH was well known for good palliative care and residents being supported to die comfortably in the care home as opposed to being taken to hospital where they were cared for in an acute setting with people by were not familiar to them. All participants also agreed was NH less concerned with complaints as these were not a priority KPI. JMT expanded that the KPI for staffing ratios in view of dependency levels was critical in ensuring a safe and conducive environment that would allow PCC to be practiced and for staff to apply theory in their practice without the pressure of working short staffed, which could create a culture of task orientation leading to poor standards of care.

JMT cited that ‘certain KPIs’ were periodically tracked which included bowel and bladder care, continence management and management of deprivation of liberty safeguards, as these were areas that impinged on human rights, choices and preservation of the dignity of each person in NH’s care. The aspects of choice, dignity and rights of residents they explained fit within the CQC standards on which NH would be inspected.

I sought to explore from participants how KPIs were linked to learning. SMT informed me that audits and quality assurance of induction, probationary reviews, supervision and appraisal were completed to ensure that each staff member had clear objectives linked to the vision of the organisation and that they were demonstrating those objectives in practice. JMT clarified that the learning objectives in all provided courses specified the practice outcomes and standards expected by NH based on established KPIs. Examples they gave were that safeguarding training was designed to prevent incidences through empowering staff to anticipate, identify early signs of abuse. To also build their understanding of correct practice policies and procedure for intervening and preventing an incident from happening or support staff in knowing how and when to escalate the situation into a safeguarding inquiry. Educators emphasised that all safeguarding education was followed by a test of the person’s understanding, and when they returned to the area of practice, they were asked to review previous safeguarding incidents and learn from those case studies.

JMT however felt that the introduction to education of case studies based on real scenarios picked up through KPI audits linked practice to theory through the KPI system. SMT supported this, saying ‘use of case studies from the KPIs allows the staff to learn from what is happening to understand how to prevent re-occurrences’. Most participants also expressed that minutes and action plans from the quality assurance meetings were disseminated to staff at different levels so they could also learn from the action plans and recommendations made by the various governance boards. JMT said this was a way of creating transparency and encouraging a culture of learning from incidents and trends across the organisation. When I prompted the participants to share which stakeholders were critical and involved in the information sharing, participants outlined that all care managers, lead nurses and department heads were involved in the sharing of KPI outcomes and any action plans or recommendations. This included trustees, who were members of the care governance and main boards of NH.

4.1.5 Stakeholder group 5: Lessons learnt in the past in relation to NH creating a learning environment

I asked this group of participants consist of educators who worked as senior health care assistants, team leaders, health care assistants, JMT and SMT questions designed to explore lessons learnt in the past in relation to NH creating and implementing a learning environment. My first question as indicated in appendix 10 (stakeholder interview questionnaire) to the JMT, SMT and educators was to reflect on the outcomes of the initial evaluation of the project. SMT fed back comments such as ‘it was a very impactful project’. They explained that changing the culture of learning from basic training—where expectations were for staff to attend a workshop or session and get marked for attendance—to education, where knowledge was tailored to the needs of the organisation to shape the practice outcomes—transformed the performance of staff. One participant added that:

through a learning environment, staff were able to start developing and demonstrating competencies in practice and specific skills in certain clinical areas which improved the standards of care for our residents.

Educators and JMT gave further examples of what this transformation entailed, stating that staff attitudes towards their job had changed. A comment was shared that ‘there is more teamwork as everyone’s goal is to deliver the best care they can to each resident’. Both also highlighted that NH was chosen as the care home of the year 2019 for best practice and care outcomes in the industry. Their assessment was this achievement and recognition was a direct result of the introduction of a learning environment. SMT proudly reflected on previous CQC outcomes that indicated that NH was within the top 3% of outstanding care homes during the time of the research interviews in 2020. Educators stated that staff participation in learning increased with completion of courses and training, on average by over 85%. They also saw an improvement in the general performance of the team as most care needs were met, resulting in overall care plan evaluation compliance of over 86%. SMT and JMT participants who were involved in governance stated that KPI outcomes in the previous year had risen from 50% to a range between 90–100% especially in education, complaints, staff supervision, safeguarding and deprivation of liberty safeguards.

Notwithstanding all the comments above, SMT indicated one area that participants felt was critical to sustaining the standards of care in the organisation given the effort and investment

made in education and development was the staff turnover rate, which had dramatically decreased in the previous two years from an average of 25% to between 8–11% in the year 2019. Participants stated that this was a significant achievement given the industry average of around 35%, and acknowledged that the learning environment had meant that candidates were attracted to NH because of its reputation as place where one could develop and grow one's career. One participant shared that:

five years ago when I started here it was a different place but because of the learning environment, learning in practice, it has now become a conducive place to work. I cannot think of my career being anywhere else. Learning here is better than even a university. Standards have improved since staff are confident, competent and now delivering the best care that can ever be provided.

This was supported by JMT who shared that staff sickness levels declined from 40% a few years prior—especially in the high-dependency households with heavy nursing, palliative care and dementia care needs—to 10% or less. They added that this 10% was genuine sickness where staff either had an elective operation or had suffered an injury that made them unavailable for a long period of time; as opposed to sporadic sickness caused by fatigue, overwork and stress.

Another participant added that lateness was another key area related to staff attitudes that had improved across the organisation: in one particular household it had been 60% and this had declined to 0% over the previous year. They also explained that the impact of lateness on teamwork was negative and meant that staff missed crucial handover information, which could often result in residents' care needs not being met as staff did not have the right information for that day. In line with staff attitudes improving, participants also mentioned that staff were having more accountability and taking more responsibility and ownership over their own learning, practice and action plans. JMT suggested this to have improved collaboration between the MDT and how care was anticipated and evaluated, with relevant changes being made immediately to meet changing care needs, especially in managing palliative care and acute illness. SMT concurred that while complaints had gone down from around 15% to 2%, compliments had increased by 25%, especially in the areas of EoLC, admissions, dementia care and staff behaviour and attitudes. Educators acknowledged that this was a significant point that reflected the change in culture in the organisation and how relationships between staff, residents and relatives had come a long way to be in such a positive state.

I explored with the participants to consider what could have been done better. SMT pointed out that at the beginning of the launch of the learning environment as part of the CHEC, educators and assessors—as key stakeholders—could have been involved more so that they had better foundation knowledge of the whole project before they took on their roles. Educators agreed this could have encouraged more confidence and empowerment so that they were able to also share their positive experience and therefore attract more staff with the potential to be developed into the roles, and resources could be quickly established to avoid excess pressure on just a few team members. However, JMT did say that the enthusiasm and support provided meant that the project was not affected; however, in hindsight the time take to implement the learning environment could have been reduced considerably had this point been considered in the first place. It was felt by JMT that there was an underestimation of how much demand would be placed on existing educators and assessors, who were also completing other functions within their contracted roles. Educators' views were that it would have been more beneficial to recruit full-time educators and assessors to be part of the implementation team as this would have ensured they had a dedicated focus on the project to provide the much needed intense support to staff who were anxious, reluctant and unsure about the new education system and how it would impact on them.

SMT and JMT both suggested that succession planning and recruitment of educators and assessors for the learning environment to identify key people who had the skills and vision should have commenced at the onset of the project. They deeply felt that having some key staff leave meant that their roles and responsibilities could not be easily replaced as they were subject experts on which the organisation relied. An example given was that among the 370 staff, until recently, only one was a fully qualified internal quality assurer (IQA). While this was adequate when the project commenced, educators felt the organisation could have benefitted from having two other people going through the process of being developed given that the IQA qualification enrolment requirement was at least two years' experience as an assessor. They suggested that NH should have planned for at least three staff being seconded to that training, rather than only one. Their rational for this is was as the project picked up and there were more learners needing signoff for their City & Guilds Level 2 qualifications, the process for their assessment and completion was slowed because it relied on one person. They were sure to meet the demand, external consultants were used until internal staff, who later commenced their courses, had completed the necessary training. JMT supported this point and further that highlighted that external consultants had standards, expectations and focus areas

that were completely different from NH's learning objectives and focus. They had observed this had caused issues with some learners who did not want to proceed with the external consultants, having compared the level of support in time commitment and resources provided with that for colleagues being supported by NH's IQA. The situation however was resolved when NH managed to recruit a couple of fulltime nurses who already had the IQA qualification and supported them through induction to ensure they were abreast of the CHEC project.

Educators pointed out the other area of learning and improvement that could have been managed differently was the initial skills analysis process conducted at the beginning of the education strategy to map staff's skills and abilities to engage with the new learning library, platform and learning application. Results underestimated the capabilities of some of the staff—particularly those whose first language was not English and those over 60 years of age as this was a self-assessment where staff rated themselves and did not provide an accurate reflection of their levels. Educators say this was highlighted when subsequent education audits indicated that staff in those categories were far behind in their learning because of low reading, IT or English language literacy levels. They thought the introduction of the eLearning platform meant that extra support was required to train staff not only in the use of IT but also in how to navigate the virtual learning environment effectively to benefit from it. Although initial surveys had only indicated only low-level issues, when the system was introduced, the demand on educators was huge. This took them away from other areas for a while as they had to provide one-to-one support to specific staff. Whilst JMT shared the same view, they say however this was later addressed by accessing volunteers from among residents' relatives, and students from local colleges and universities, who were willing to buddy and offer support to those team members who needed the extra step-by-step help. SMT said the learning journey plan for those staff was also adjusted to reflect realistic goals that were achievable over longer timescales to keep them motivated and remove the pressure of learning new skills while going through the education process. Educators and JMT felt that if the skills analysis had been conducted via a system such as Survey Monkey this would have revealed the actual level of competencies of staff as they would have had to use the computer to log on and complete the survey, rather than completing a hard copy survey where they exaggerated their capabilities, resulting in extra, unanticipated resources being required to overcome skills gaps.

The final question I asked this stakeholder group was what they would avoid doing again in relation to implementation of a learning environment. SMT confirmed earlier comments that

educators were key to the learning environment and it was impossible for them to reach their maximum potential and impact if they were performing this role alongside other responsibilities. JMT shared the same view and gave an example, being a nurse as the main role and supporting education as a second role, which may be allocated to 15–20% of their contracted hours. SMT and JMT agreed the effect of this was that more educators were required to be developed to reach the same level, whereas it would have been better to have a small group with more experience through having spent their full-time hours in the role. This would also have provided consistency in practice and built a relationship with the learners (staff) and facilitated tracking, evaluation and adjustment in learning patterns and interventions depending on the needs of each staff group. This was not achievable as educators were only doing this part time and were concerned mostly about their main role.

JMT stated another point that instead of recruitment of staff based on experience and training, NH had begun using values-based recruitment—where candidates were more likely to be selected if they demonstrated values that matched those of the organisation—more staff that were new to the care industry with no background of working in a care home were recruited which was a positive thing in terms of creating the right culture. However, it was noted by educators that such staff required more introductory education before being supported into their roles and expected to learn on the go which was a challenge to them. JMT thought although this (learning on the go) was an advantage to staff who already had exposure to what to expect in a care home, recruitment audits for turnover indicated that some of the staff who had left were within a few months of having commenced. JMT observed that NH's expectations of care and the standards it had set were much higher than those staff had imagined. While educators concur that working in care is not for everyone, they have a view that if these staff had potential, this could be realised if they were supported to commence their induction and online learning before their physical start date. They believed this would prepare them better for working in NH whose practice differed from that in other care homes. Furthermore it would also have reduced 'culture shock' and pressure relating to how much they had to learn while trying to understand the care industry and all its regulations, protocols and procedures. JMT admitted that in some circumstances, existing staff struggled to engage with this particular group of new staff as the gaps in knowledge and skills were so wide that they felt it would be challenging for the new staff to get up to speed during the period of their probation.

SMT participants stated that a learning environment of this nature in a care home was a completely new concept and the way it developed at NH was in response to the uniqueness of the residents, staff, leadership and environment. When I explored more with participants if they had any further comments, they added that, notwithstanding the comments already made:

I can't think of anything I would avoid because everything we did was new and we were exploring what works. All the experience gained through the process was important as it taught us well.

Others added that, 'this was a very good vision that came into fruition and successfully done', 'a lot of people did not think that it would work but it did and 'good leadership, educators, team collaboration made it happen. We all believed that we could do it against all the odds.

4.1.6 Stakeholder group 6: An evaluation of whether this model was responsible for the change in standard from 'good' to 'outstanding'

This question was critical to the research question for this DBA and I selected a group of participants who represented all the staff levels at NH such as educators with health care assistant, assistant practitioner, nurses' roles inclusive of some SMT, JMT. To that effect, my intention through appendix 11 (stakeholder interview questionnaire) was to explore questions designed to evaluate whether this learning environment was related to the change in CQC standard of care from 'good' to 'outstanding'. Educators and JMT highlighted that each of the learning outcomes from the education that NH was delivering was tailored to a specific KPI outcome. They clarified further that the KPI system was designed with the CQC fundamental standards as the foundation for the categories and individual aspects included in the audits. They shared the examples listed in Table 4.1.

Learning objectives	KPI outcomes
Common induction standards: PCC principles, privacy, personal care, choice	Zero complaints each quarter, at least one compliment from each resident or their relative within the year, zero safeguarding of vulnerable adults
NH's values: compassion, respect, excellence,	RCC, MDT collaboration and response times, deprivation of liberty safeguards, bowel and bladder care, continence

Learning objectives	KPI outcomes
dignity, integrity, teamwork	
Tissue viability, wound management	No Grade 4 pressure ulcers, reduced incidences of grade 1–3 pressure ulcers, no sepsis due to wound care issues
Falls prevention and management	Reduced incidence of fractures, reduced unwitnessed falls, reduced incidence of frequent fallers, reduced hospital admission due to falls
Medication management	Reduced medication errors (by 40%), improved polypharmacy and deep prescribing due to collaboration between GP and pharmacist
Managing symptoms of a dying patient, syringe driver care	Compliments in EoLC; 95% of deaths in preferred place of care (NH) instead of hospital, 100% successful implementation of syringe drivers at onset of symptoms, 0% complaints about care
Nutrition and hydration	30% reduction in weight loss, 15% reduction in hospital admissions due to dehydration
Improving risk management	30% reduction in incidents relating to resident injury due to equipment, resident-to-resident behaviour
Understanding frailty	98% successful new admissions, 85% care plans updated and evaluated with specific care outcomes being met; reduced incidence of preventable hospital admissions
Understanding dementia	Reduced incidence of distress, 98% successful placement into dementia-specific care households, reduced safeguarding incidents
Principles of RCC	Improved communication between relatives, resident and keyworkers and hence increased compliments, better partnership and collaboration with the MDT, which resulted in

Learning objectives	KPI outcomes
	reduced unnecessary hospital admissions, polypharmacy and deep prescribing
Prevention and management of infections	Reduced incidence of urinary tract infection (UTI), no sepsis deaths, management of COVID-19 procedures
Performance management of staff	Improved team performance, low sickness, high retention, low turnover, positive team survey results
Leadership, mentorship, coaching	Silver Award in the Investors in People accreditation, over 85% completed supervisions and appraisals, reduced turnover

Table 4.1: KPIs for learning objectives Sources: NH stakeholder interviews (2010)

I wanted to get this group's reflections and comments regarding which particular education they thought influenced changes in practice. They all agreed on the list in Table 4.1 in that learning outcomes in those areas had collectively led to significant changes in the KPIs against them in practice. JMT added that education empowered managers to comprehend how to complete quality assurance and audits in a qualitative manner so as to identify connection between theory and practice gaps. Educators agreed this reformed the culture and practice in that managers valued the audits as enabling tools, as opposed to a procedural exercise they completed and forwarded to the governance team. SMT seconded that enhanced understanding of how quality assurance could be utilised to develop trends analysis and connect this to reflective discussion with staff also contributed to a shift in management styles, where they sought to explore, reflect and support staff based on trends outcomes instead of being reactive. Additionally, JMT stated how this empowered managers to start leading their teams differently by analysing strengths, weaknesses and skills and using this to complete workforce planning to improve efficiencies, maximise skill mixing approaches when completing rotas and offer more training in the specific areas that required more focus based on the trends analysis.

With this change in leadership or management style, educators believe that one positive effect was that staff felt more supported and started to take on additional responsibilities, asking for opportunities to develop into subject experts. They felt it boosted the efficiency of the teams and subsequently their overall performance. One participant stated that 'nurses are attending Level 3 qualifications in EoLC as they now want to also support the care staff and deliver tool

box training while in practice’. Another participant said that there was more openness and transparency in terms of care practice, such that residents and relatives were now being supported to participate in education, especially in falls, dementia and EoLC. JMT went on to explain that staff were no longer feeling the barrier that had previously existed between the relatives and them; rather, they saw each other as partners now, which was one of the outcomes of the RCC education. JMT’s observations were that trust built in the partnership meant that a positive approach to care was considered and the principles of PCC could be applied easily as staff connected better with residents and those who mattered most to them. All participants in this group acknowledged that this environment had allowed the practice and culture of staff and relatives asking questions and constructively challenge decisions, care plans and certain procedures without fear or worry of creating conflict.

It was imperative for me to capture this groups thoughts on what competencies improved as a result of learning environment. All the participants stated EoLC as the biggest area of improvement given that on average 60 residents died at NH each year. SMT felt that there was a clear care pathway for each resident as symptom management had significantly improved now that staff could anticipate care, coordinate with the relevant MDT member and ensure that the appropriate anticipatory medications were in place for when they needed them given the various symptoms that could arise through the journey of the resident in their final days.

Alongside EoLC were additional comments from JMT regarding clinical skills to manage percutaneous enthal feeds, as a number of residents in NH had these in situ. One participant said that ‘staff are so competent now, you only have to look at the quality assurance audits and results to see all the areas which are green’. The participant was referring to the KPI audits (Appendix 2), which demonstrate trend reviews for all the clinical areas NH had set for itself to meet as part of its excellence focus. Educators and SMT furthermore cited the learning outcomes in Table 4.1 as the areas in which they had seen competencies changing significantly across the organisation.

JMT however indicated that one area not on that list is fire evacuation procedures. One participant mentioned this was a huge issue as the fire procedures had recently been changed and staff had to relearn the process to support residents, especially given the frailty levels and the current situation with COVID-19. They explained that the workshops and practical exercises that had been delivered developed the confidence and competencies of fire marshals, incident managers and response teams, which were all part of the staff at NH. This participant

was also highlighting that the learning environment facilitated staff learning new skills that were not primarily related to their own role but included any skills to which they wished to expand their focus. They also used this as an example of teamwork having improved due to the confidence and ability to proficiently communicate with one another.

SMT shared that competencies that improved were assessment of comorbidities such as depression, pain and malnutrition. On participant added that completing these assessments effectively was paramount to identifying early warning signs of deterioration so that immediate interventions were put in place to prevent deterioration and complications in frail residents. They added that they had noticed advanced competencies in deciding treatment plans for residents once assessments were completed, and the use of clinical techniques such as aseptic, universal precautions and donning and doffing for infection control purposes.

Furthermore I asked participants to consider what other skills had improved with reference to staff's practice in particular. JMT identified that the ability to reflect on a personal approach to care and critically analyse what could have been done differently with a view to considering improvement opportunities had changed. One participant explained that previously, staff would have been very defensive if a manager or other staff member had initiated a discussion regarding a procedure what had gone wrong. This was always seen as a negative discussion by staff and thus blame and fault were the driver of resistance to personal reflection. This participant added that reflective practice had become a useful skill for some staff in leadership roles because it helped them to improve not only their interpersonal skills—as they considered how they could deal with their direct reports in a more supportive and coaching manner—but also how they motivated their team to inspire them to do more.

Another JMT participant established that it was the leadership skills of nurses that were a surprisingly positive outcome. This was said in reflection on previous practice where nurses and care staff were always not integrating well and this resulted in a fragmented care approach. Another participant added that time management as a result of better leadership had been a positive skill that nurses were demonstrating. They explained that this allowed nurses to have quality time with residents, assessing and engaging with them on a personal level where they could really understand what changes were taking place and complete comprehensive assessments without rushing to complete multiple tasks. Another JMT participant added that, generally, managers and team leaders had become much better in their planning and ability to prioritise and coordinate care needs depending on demand and unexpected events during shifts.

Another JMT area reported to have significantly improved was the ability of nurses, team leaders and SHCWs to delegate effectively with clear direction and expectations, ensuring that they were delegating to the most relevant person who could deliver the intended outcomes for that particular activity. Educators, SMT and JMT participants agreed that these skills were critical in facilitating smooth running of daily care, a conducive environment for the team to perform better and for everyone to have enough time to practice, learn and reflect on the care being delivered and not have a task-oriented approach, which impacted negatively on the experience of care to the resident.

In addition, I wanted to know from participants what staff knowledge had improved in practice apart from skills. One participant who was an educator stated that 'it feels like everything has improved, it's like a river flowing with knowledge'. All participants referred back to the learning outcomes in Table 4.1 but added additional ones such as managing dysphagia and dysphasia, oral care, safe moving and handling, basic life support, cardiopulmonary resuscitation (CPR) and policies or procedures of NH. SMT felt that most staff had also improved in managing residents who require a texture-modified diet or were at risk of choking and silent aspiration. This was again considered a high-priority area of practice given the number of residents at NH who were at risk due to frailty, dementia and dysphagia-related comorbidities. One participant indicated that they had seen a significant reduction in lower respiratory infections that may have been attributed to aspirational pneumonia.

This group of participants provided feedback on the coaching and mentorship skills of the team leaders and SHCW when supporting students coming for placement, and ensuring they were meeting their learning objectives. They felt this was important because the art of coaching a student is completing nursing-facilitated cross-fertilisation of information and learning to the staff who are mentoring them.

Literature review indicated that transformation happens when staff are confident in their skills, knowledge and practice. I therefore questioned this group whether they thought staff had improved in their confidence and how they thought it contributed to the practice outcomes. This question arose from the literature review because unless staff are confident in themselves and their capabilities, they find it hard to transfer knowledge and skills in to practice. All the participants responded that confidence had definitely improved. Comments included:

when we place our carers to work with student nurses, you can see how the carers explain, teach, show how to do things and the reasons for doing it that way. The carers have now become teachers.

Other feedback included that confidence even among assistant practitioners had improved significantly. They were reported to have taken more responsibility and accountability and referred to their own practice development plans. One participant commented that:

staff are so confident that they are able to challenge each other about practice issues. This shows ownership, alignment to the same goal and vision. This facilitates change in culture.

Another suggested that ‘staff fully understand the vision and so audits indicate staff are doing the right thing’. This was supported by another comment that:

confidence has definitely improved in staff, SHCWs are now able to work independently, and you have less referrals of incidents to the managers. And you get a detailed report with actions which show initiatives, accountability and ownership.

Further comments by the SMT were that staff felt empowered through the skills and opportunities they had been given. This was evidence from staff who were developing their careers to become leaders and assessors. It was noted by JMT that staff were also feeling confident in speaking out when things were not going well, instead of leaving it to management. This was supported by one participant, who said ‘staff’s behaviours have changed as a result of the confidence. They are taking on project responsibilities, taking initiatives and participating in improving care’.

My final question to this stakeholder group was whether they thought that the learning environment at NH had improved the standards of care there. All the participants responded that the eLearning environment had definitely transformed the organisation into the care home of the year in 2019 and given it Platinum status under the Gold Standard Framework (GSF, a national awarding body for standards of EoLC in the UK), an ‘outstanding’ CQC rating and best placement provider of 2018. They suggested that the ability and provision to translate knowledge into practice by having to demonstrate skills and competencies was key to the performance of staff. SMT alluded that the learning options, structure and relevance to NH’s expected outcomes had enhanced how staff could become proficient in meeting the standards of care expected. One participant stated that ‘100% that it was the learning environment. Staff used to be task oriented instead of identifying the links between all areas of the learning and

the KPIs'. They went on to explain that the learning environment linked theory into practice outcomes through the designed KPIs, which meant that all staff's focus was connected and everyone could see how to achieve the organisation's vision through education. This was supported by the comment from an educator that, 'staff are very positive and residents as well. The whole concept of understanding care needs has changed'. This participant also explained that when residents felt heard and staff were able to listen to residents and understand what to do to meet their needs that was how outstanding care was delivered. Another supporting comment shared by a JMT participant was that 'learning and not training is the only way to ensure that staff know what they are doing'. They went on to say that 'I am confident now that if CQC ask about deprivation of liberty and infection management, staff will respond appropriately'. That comment was made in further reference to recent changes in the two areas of practice that otherwise would have been complicated for carers to understand and demonstrate knowledge in.

Participants in this group referred to the KPI trends, which had significantly improved, and stated that this was because of the way staff were now educated. They mentioned that standards across all departments had been raised as staff were individually identifying what needed to change in line with the vision and values. One SMT participant shared that 'values are not just on a piece of paper or poster, our values are acted and lived in NH because of the learning environment. This was supported by another participant who said that:

five years ago I wanted to bang my head on the walls because of how things were. Change in culture since then has led to knowledge improving in everyone. We are able to question, evaluate care all the time as part of our daily practice. Even managers are learning through reflective meetings.

It was the view of all participants that the process through which NH went in developing and implementing the learning environment through the CHEC project was significantly impactful in transforming their standards of care from good to outstanding over the previous three years.

4.1.7 Stakeholder group 7: Recommendations on how this model could be disseminated across the industry

This DBA's interest is for the research outcomes to be shared across the industry should the outcomes prove that creating a learning environment did in fact improve standards of care at NH. Subsequently, through appendix 12 (stakeholder interview questionnaire) this question

was addressed to the participants from the SMT, educators and JMT who were involved in the construction and implementation of this project to explore how this model of learning environment could be disseminated across the industry. The purpose of these interview questions was to explore how practical the model was and applicable it would be to other settings that may be different from NH. The first question I asked was in relation to which aspects of the model were replicable. SMT identified that the vision to become a centre of excellence was replicable. They described that a centre of excellence in this model was defined by a care home that was a care, learning and research environment designed to support CPD of staff and to evidence best outcomes in care. They explained that any care home could aspire to starting its journey small and then build up its capabilities and resources over time towards changing its culture and way in which it views education.

One SMT participant explained that introducing aspects of skills analysis for the staff and mapping those against residents' care needs and challenges faced by the care home in meeting those needs was a simple approach that anyone could follow. The participant went on to add that once this was achieved, the organisation could follow up and identify where gaps were and consider what education or training they needed to introduce in addition to the mandatory courses they were running. This notion was supported by JMT who said online eLearning platform was considered a simple but effective tool that could increase the resources for education by making over 200 courses available to the organisation. Both SMT and JMT were united in the view that the course library could be tailored to each home based on its types of care needs to keep costs down instead of purchasing all courses. They highlighted the advantage of using the eLearning platform as opening up opportunities to learners to access more courses anywhere and anytime. This was considered a huge benefit, which meant that more staff could start to learn even outside their working hours.

JMT were explicit in that introducing qualified educators and assessors as part of the teaching resources was achievable by other care homes. They considered that the cost of training each educator was far less than the cost of using an external provider to deliver courses to staff over a year as most homes were doing. SMT seconded that advantages of this was that the home was using its own committed and dedicated staff who knew the organisation well and therefore could tailor the delivery of education to meet the care home's vision and learning needs based on skills gaps identified. They also shared that creating a CPD pathway was also replicable once the learning resources, educators and assessors were in place. What this entailed was

changing the induction, supervision and annual appraisals to have a structure that identified learning objectives for each staff linked to the intended KPI outcomes of the home and supported by the education resources available, as described above.

The educators explained that this process was achievable as it only required management and HR teams to review the organisation's strategy, policies, procedures and forms. They thought organisations implementing this project would need to train staff in how to undertake effective supervision and appraisal in line with the new approach but such training could be easily tailored in house. Their view was for smaller organisations that did not have an HR team, this could be done by the home manager or their deputy to set new expectations for how to manage and support staff to grow. Failing this, courses on coaching and mentorship were available to managers and clinical leads in the industry. One educator added that creating an eLearning environment involved partnerships with universities in their geographical areas, especially those that offered health care-related courses. They said care homes could explore what opportunities were available to support placement of students within their home as this would generate opportunities for change in culture and learning between the students and staff.

Another educator suggested this would, 'create a motivating environment for staff and set a high standard of education'. This comment was made in reference to the point that current learning within the industry was basic and so changing the way homes approached learning—including case studies, reflective practice and co-working with students—would alter the way staff acquired information in practice, not by just sitting in a classroom or completing an online course with practice expected to improve after a theory session. Other educator participants suggested that introducing research was an easy way to facilitate this by working with universities that focussed on health care. Their reflections on the process undergone by NH led them to consider that it was possible for other care homes to link with research universities in their area and discuss opportunities for researchers to conduct research activities at the home. They reflected on how NH managed to attract researchers who provided education to the staff as part of the research partnership. They identified that researchers would often challenge the thinking of the team through their questioning and exploring how things were done.

JMT agreed and suggested advantages of this is applicability was that learning was also a consequence of this process as researchers would share their outcomes and recommendations, which would immediately provide solutions to improve plans for the home at no cost.

I asked participants to reflect on systems that were common across the organisation. The purpose of this question was to explore existing opportunities that did not require homes to invent new processes to implement a learning environment such as that at NH. JMT shared that clinical education for specialist subjects such as tissue viability, palliative care through the GSF and resources to support mandatory training could be built on to extend the learning to other subjects. SMT identified the GSF process in particular as its focus was designed to improve the quality of education, care delivery and processes in care homes across the UK with the intended outcome of improving standards of care. Educators concurred with this and cautioned that although it was focussed on EoLC, there were a number of activities that each home had to complete to develop the capabilities to support their learning, manage care challenges related to end of life and link with local hospices, which would also become their support and partners through the process.

All participants shared how care homes had to undergo accreditation following audits and visits from GSF inspectors who came to evaluate standards in the home, in a similar way to CQC. JMT stated that granting this was a paid service, almost 40% of care homes across the country were engaged with the framework, which meant it was affordable and achievable. Their view was as more homes were now going through the process, there were also opportunities for care providers to share learning, teaching and other resources to support each other and develop together. They also identified that the eLearning platform was available across the industry and included providers to meet any budget. However, educators also highlighted that within the industry education to develop educators and assessors was easily available and accessible even online, which made it easy for key staff to access within their own time and go through the learning. They suggested a need for workshops educators would need to attend to develop and demonstrate competencies, but the eLearning was available and flexible to fit in with the busy schedules of staff working in 24-hour care home environments.

It was necessary to explore participants' recommendations on what resources could be shared or accessed by providers from NH to make this project affordable. The purpose of the question was to identify how other care homes could learn directly from NH so they could start their journey to transform their practice through a learning environment. SMT stated that NH already conducted themed workshops for other homes on how to create a learning environment. This was something they envisaged could be continued as a way of sharing good practice with other managers and leaders, as well as commissioners. Through my interactions with NH, I note that

the organisation's leadership had been invited as guest speakers to a number of national events to share their experience and encourage other providers to learn from what they had achieved.

JMT suggested the option of consultation visits to the home so that leaders who were interested could take a tour and observe the learning environment in progress. This again was something participants highlighted as already happening with many care homes, not just in the UK but across the world, as NH was now recognised as a place to visit and learn new innovations in practice. Educators considered that current education workshops at NH were offered to other homes, especially in key subjects like EoLC, dementia and PCC. Care homes in South London had been sending their managers, clinical leads and proprietors to attend sessions organised by NH.

One JMT participant stated that NH was already acting as a centre of excellence by educating other providers who came to spend time at NH. They mentioned mentorship relationships with other care home managers in the South London area that met at NH to learn and reflect on good practice. Educators mentioned the placement of learners at NH for the South London Partnership Alliance where key staff being seconded to different organisations could spend time at NH learning about dementia, palliative care and PCC. This was extended to placement of nurses, assistant practitioners, therapists, public health, speech and language therapists and many other disciplines who were placed via their institutions of study or work. SMT said that NH had become the learning hub within south London where other staff came for development of knowledge so that they could become champions who would return to their workplaces and implement the knowledge they had attained.

Furthermore, JMT highlighted the mentorship partnership with other charity homes across the UK who seconded their leadership teams to spend several days at NH shadowing its Senior Leadership Team (SLT) within designated areas of practice they were interested to learn in practice. JMT said the relationships that developed between visiting senior staff and the team at NH were continuous as staff kept in touch and began to share practice ideas that benefitted both organisations. They were confident that another way in which NH had been able to practically support the industry was through workshops with Health and Social Care faculties at universities where the NH's SMT had been delivering employability workshops to postgraduate students over the previous two years. These sessions covered the learning environment concept introduced at NH as part of the CHEC and encouraged graduates to consider a career in the care home sector. There were two universities for which these

engagements were organised. One university began placement and supported recruitment at NH as a result of interest generated through these engagements.

Educators suggested that learning materials such as workbooks and the supervision and appraisal template designed would improve the way education was tracked and fostered in practice. They said whilst these workbooks would have to be tailored to the individual organisation at least there would be a foundation and clear example they could follow without having to spend excessive time and financial resources to develop systems from scratch.

SMT communicated about sharing research outcomes as NH was already advanced in its research capabilities and had substantial support from a number of universities. They confirmed this would not have any financial implications for NH or the other partnership care homes as research activities are fully funded by universities or through other external funding resources. JMT stated that there was an opportunity for NH to operationalise the CHEC model and begin to offer consultancy services to other homes looking to implement the same system. In view of the resources and capabilities already existing in house, qualified educators, assessors and subject experts may in future be able to go into other homes and develop, educate and support education transformation through the accredited CHEC model they have developed at an agreed cost. They expressed it would not only benefit NH but would extend the possibilities for this model of learning environment to be shared much more widely with practical support associated with it.

The final question I had to this group of participants was whether they thought this model could be published in an easy step guide of how to implement a learning environment, which could be made available to other homes. The purpose of this question was to assess how easy it would be to replicate the model without relying on NH being the main driver of the change. All participants' views were strongly aligned that it would be possible to produce an easy guide. One participant stated that 'we are confident of how it works and what parts to start with to build up capabilities'. Another participant added that:

yes it is possible, considering the challenges faced by care homes across the country, most issues are similar and therefore if they follow the process, they can achieve the same outcomes.

There was however caution from this group that leaders would need to be supported and developed to have a better knowledge and understanding of the key principles that would bring

about cultural change, especially in relation to learning and development of staff. This was aspect in which NH could educate leaders who could then provide that further education to those willing to start their journey.

4.2 Secondary Data

Having collected primary data from the 30 participants, my next step was to collect secondary data surrounding NH's learning environment with a purpose of comparing it to the feedback from interviews collected. Hence the table below illustrates the secondary data that was collected with reference to the stakeholder groups interviewed.

Primary data	Secondary data
Stakeholder interviews with: Trustees Director Managers Quality improvement lead Educators Senior HCAs Assessors HCAs Nurses Team leaders	NH documents, records, files 2016–2018 CQC inspection reports Five-year strategic plan Care Home Education framework Governance minutes, reports Learning KPI outcomes, audits, trends analysis Training records Policies Procedures

Table 4.2: Empirical evidence Source: created by Author 2020

The first set of data I gathered related to evidence of standards linked to learning through practice. I understand that within the industry, CQC inspection reports are considered a useful evaluation of how an organisation is supporting and developing its staff to meet set industry standards of care effectively, their outcomes are the national and industry measure of performance for care homes. Furthermore, CQC considers that with the right education and support, team members will be able to demonstrate the appropriate skills, knowledge and competencies expected, as part of bi-annual inspections. I accessed NH's reports from 2016 till 2019 which were available at the home, it is a regulatory requirement for a copy to be available

to their stakeholders. Additionally, I had access to the CQC website to access further information recorded about annual inspection outcomes for NH. These helped to establish how well NH performed against other providers within the industry following their introduction of a learning environment.

I felt it was imperative to explore NH strategy to improve its standards following the 2016 inspection in light of what the participants shared regarding policies and procedures. To that effect I included NH's five-year strategic plan, available as electronic and hard copies. This plan was critical in providing the road map and priorities for the organisation's learning agenda. Furthermore, participants shared the connection between NH's vision and learning in practice, therefore I felt this was essential to establish what specific, measurable, achievable, realistic and timely (SMART) objectives were deployed to facilitate this.

Alongside the five-year strategic plan, had access to key performance indicator (KPI) documents relating to the standards set by NH pertaining to the learning environment. My aim was to compare and contrast evidence of areas of improvements as outlined by the stakeholder participants during interviews. I also felt KPIs were a good indicator of what learning methods and applications worked, allowing an analysis of how and why it worked in comparison to the literature reviewed in chapter 3. The education framework and NH's governance minutes were integral to secondary data as they outlined how the implementation process worked and what changes were made along the way to ensure the targeted outcomes were being achieved.

This is critical for the recommendations in chapter six of this thesis as some of the mistakes and changes made through the implementation of the learning environment may inform other providers in the industry about approaches or processes that may not work well based on NH's experience. Stakeholder participants referred to the effectiveness of NH's policies and procedures relating to education, workforce development and management also formed part of the secondary data used to explore the structures, systems and processes that NH included to change its culture and create a learning environment. This prompted me to consider these as part of the data collected and reviewed in this section as they could also provide a building block for other care homes should this project be applicable to the solution to the industry's standards improvements.

Among all the secondary data reviewed, I identified that the connecting framework for all this evidence was the KPIs for the organisation, as these provide evidence of learning directly

related to standards of care. Table 4.1 highlights the KPIs on which NH focussed to direct learning, measure improvements and influence the standards of education, practice and care delivered. It also presents a summary of progress in relation to each KPI between 2016 and 2020, which enables a predictive analysis of what NH could achieve should it maintain its standards until the next inspection.

The secondary data were compared with the interview data from the perspective of the staff who worked and experienced the learning within the organisation. This also enable validation of any feedback from the participants and KPI outcomes from 2016 till 2020.

4.2.1 Industry Performance Standards data Relating to Learning at NH

As established in Section 1.1, CQC is the regulating government body that oversees performance and standards across the health care industry as a whole. Its inspection visits to NH over the four years prior to this study were themed and targeted to evaluate and accredit the organisation against the 16 standards set by the Department of Health and Social Care through the five KLOEs. Visits between 2016 and 2020 were conducted via the SOFI. This involved a team of inspectors visiting over a period of two to three days reviewing documents relating to NH's policies, procedures, quality assurance and strategic plans for improvement. During NH's inspection visit, inspectors also focussed on evidence from interviews with residents, relatives and staff to establish how the organisation was meeting care standards. My data collection was particularly focussed on the KLOEs as these are underpinned by a CQC regulation dealing with the learning requirements demonstrated by NH: Regulation 18 of the H&S Act stipulates the kind of learning providers must offer staff. Figure 4.2 compares NH's KLOE outcomes in 2016 and 2018.

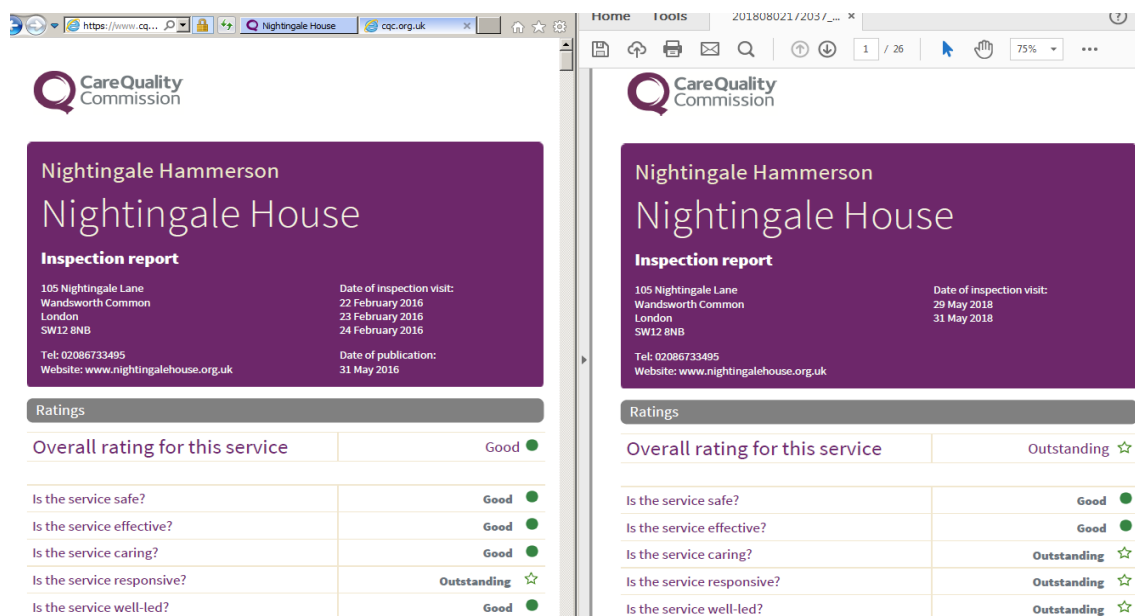


Figure 4.2: NH's KLOE outcomes in 2016 and 2018 Source: CQC.org (2020)

In my research I established that KLOEs were introduced following NH's 2014 inspection; hence NH's 2014 inspection outcomes could not be directly compared with later ones. However, I noticed from previous reports available that NH was generally meeting the basic standards, as there were no recommendations or requirements, particularly in relation to Regulation 18. The significance of the KLOEs from 2016 onwards is that they distinguish between meeting and exceeding basic standards. Figure 4.2 highlights that NH in 2016 was outstanding in its responsiveness, representing the first 'star' it achieved under the new system. The inspection report states that it was proficient in how it dealt with workforce management and development. The report also outlines the strategies in place to address staff turnover, induction, training and any shortages or gaps NH was experiencing. The inspection occurred at the height of nurse shortages and high turnover of staff throughout the industry.

Regulation 18 of the H&S Act (2008) focusses on learning states; in this sense NH had to demonstrate that it had in place adequate and suitably qualified staff to support the care activities under its registration. This included all mandatory courses outlined in Figure 1.1. During the inspection, evidence suggests NH met these standards as its training records provided evidence that all nurses had the appropriate qualifications and registration to practice. There was a clear staff induction process consisting of the mandatory training required by the CQC.

4.2.2 Learning Standards and Practice Outcomes data for NH

I looked at evidence of NH's KPIs (appendix 2) developed in relation to learning objectives and outcomes they wanted to measure in practice as part of their Governance framework in relation to a learning environment. My findings were these KPI's established the education focus and priorities for the education team and managers involved in supporting staff via induction, supervision, appraisals and CPD assessments. This is collaborated by the SMT, JLT and educators I interviewed during primary data collection. Additionally, I note these KPIs in appendix 2 are categorised into five areas which were considered by NH to make a difference in its overall performance as summarised in Table 4.3., which illustrates performance outcome trends since 2016.

Category	2016	2017	2018	2019	2020
Person Centred Care (PCC)	51%	81%	95%	100%	100%
Care Quality Assurance	85%	80%	90%	95%	100%
Workforce development	51%	90%	95%	100%	100%
Learning resource management	51%	85%	95%	100%	100%

Table 4.3: NH's KPI audits 2016-2020 Source: (NH 2020)

The evidence I reviewed indicated that in the first two years (from 2016), NH focussed on reviewing its aim to become a centre of excellence and revising its mission to support and develop its dedicated team members to deliver PCC and adhere with organisational values. Its strategy was to ensure its aim, mission and values were included in each of the recruitment, induction, supervision, appraisal and staff education processes and this is confirmed by JMT during stakeholder interviews. Moreover, this evidence indicated that NH consulted with staff to review its values, which initially were compassion, respect, excellence, dignity and integrity as stated by SMT during stakeholder interviews. I discovered that following that consultation

and review, the organisation decided to include 'teamwork' to their organisational values (Compassion, Respect, Excellence, Dignity, Integrity) and formed their new CREDIT acronym which became a culture slogan for change. Stakeholder interviews stated how values were part of the recruitment process, therefore I endeavoured to review recruitment and education records and found evidence that CREDIT values were integral as part of practice expectations for all staff and were reviewed as part of performance reviews. More significantly, 2018 CQC inspection report provides evidence that NH improved in its caring standards and as a result attained an outstanding rating. The CQC report in 2018 outlines that inspector's observed evidence of staff attitudes demonstrating specific values of caring, kindness, privacy, dignity and respect in their practice. They also observed that staff involved residents in their care planning, which signified a natural culture of inclusivity and respecting residents. This evidence is critical as it demonstrates that NH was able to translate its five-year strategic plan objectives into evidence-based practice, which improved caring standards. This evidence also corroborates the feedback from stakeholder participants who described improved knowledge, skills and competencies.

Within the NH's five-year strategic planning, it outlines that the organisation aimed to creating an environment in which values were a part of day-to-day practice was the key factor to transforming staff's culture in practice. This also links to the literature review, which suggested that learning can only take place at work when the organisation creates a conducive workplace environment that allows staff to be open to new ideas and take ownership and accountability for their contributions in their role. The CQC report in 2018 suggests NH showed consistently good practice across the five care models (nursing, residential, dementia, palliative care and mixed households). The inspection included interviews with staff who reported that they felt supported and were provided with opportunities to develop themselves under the support and leadership of their managers. I considered this evidence critical as it underpinned the organisation's strategic objective in 2017 to develop NH into a centre of excellence model by creating a learning environment for its staff and introducing research as part of its model to improve care standards. The primary objective was to improve leadership capabilities and use coaching, mentorship and education to support staff. Subsequent to the 2018 CQC inspection, NH was rated as having become outstanding in the category of 'well-led'. Again, this was critical evidence for how it had spent the previous year investing in that particular objective, which had delivered positive results.

To understand how a learning environment was achieved in practice, I explored in detail the strategic plans for this centre of excellence model, which were developed and implemented from 2016 until March of 2020, when NH was due for another CQC inspection. The CHEC initiative shaped NH's systems, structures, processes and day-to-day operations. This strategy provides key information and evidence regarding how NH improved its standards from 'good' to 'outstanding' in 2018, and addresses the research questions while providing an insight into factors that may provide practical and relevant recommendations for the industry.

4.3 Learning at NH and how this Differs from the Care Sector

Evidence from my secondary data collected revealed how NH developed a learning environment through an education framework which was underpinned by an “empowerment” model of care. This was part of their 5 year strategy plan to improve education and development of staff and become the first Care Home Education Centre (CHECK) in the UK. The data I collected showed that the model was designed to create the learning environment and deliver the KPIs standards set by NH and subsequently evidence CQC standards of care. Figure 4.3 illustrates the components of the empowerment education model and how NH linked them with components involved in creation of the learning environment.

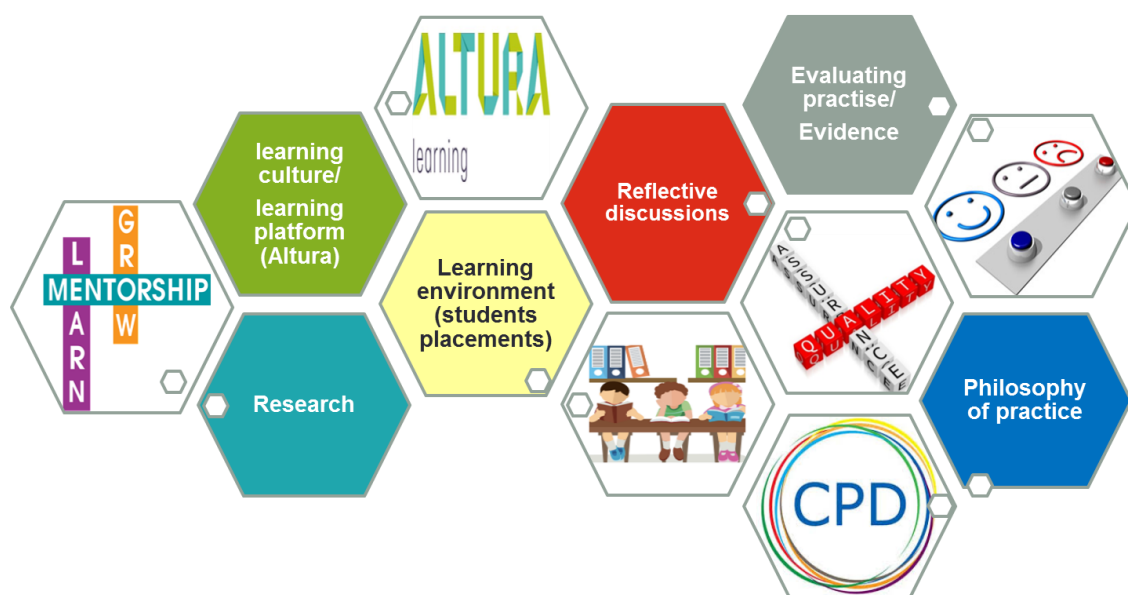


Figure 4.3: Empowerment model (learning environment) Source: created by Author (2020)

The model above is expanded in the organisation's 5 year strategy which outlined purchasing an online learning platform provided by Altura to create a learning resource comprised of 200 courses endorsed by Skills for Care. This included tailored courses as well as standard courses, which were both accredited and informal. Each staff member had access to courses allocated by their manager or supervisor depending on a skills and knowledge analysis, to form a tailored CPD plan. According to the education audits and review meetings from governance minutes I accessed, the online resource also empowered staff to enrol themselves in courses of their choice or of interest, depending on the areas they wished to self-develop. This finding connects with literature review which identified that a learning environment is achieved when staff are empowered with resources to self-develop as this provides motivation and focus, rather than organisations making training mandatory. NH offered access to the City & Guilds learning material, which included various accredited courses and modules up to diploma level. In accordance with NH's vision, it meant the education provided meaningful career development pathways and that staff could take their learning seriously because it led to lifelong career development and opportunities. Evidence of learning approach at NH differed from industry practice in that most care homes were only offering mandatory courses that were not formally certified or accredited (see Section 1.1).

The 5 year strategy outlined that to facilitate the learning model and environment, NH developed its own educators from among its team of managers, nurses, team leaders and care staff who had teaching qualifications to deliver education under the AET qualification. The rationale for this was that it would provide a career pathway for staff with an interest in supporting education in care and, most importantly, would ensure that NH educators understood the organisation's vision and challenges and were already working closely with staff. This was considered instrumental in also changing the culture of leadership, as managers supported their direct report teams through education, supervision and appraisals. This provided links through the whole process of development of those teams from beginning to end. Feedback from stakeholder interviews suggested this brought a more consolidated approach of translating PCC theory into practice.

Education policies and procedures I accessed explained NH's PCC philosophy of care, introduced reflective discussions, case study and review of practice into meetings, handovers and any significant event as a new way of establishing learning through practice. The

procedures highlighted the intention to offer staff a platform to debrief and share experiences that would benefit their learning to improve practice in a non-threatening way. Having been on site, I also reviewed the newly developed a learning hub that allowed staff to go to a quiet area away from the work environment to access their online learning and complete assessments or tests. To ensure learning was also taking place in practice to further skills and competencies, NH introduced a learning development policy that protected 25 hours of learning per year for each staff member; most care homes only provide 15 hours for this purpose.

NH's education model was linked to quality assurance through its policies and procedures for auditing. The quality assurance records I viewed demonstrated that trends analyses were used to identify skills, education and competency gaps. The Education and Development steering group, which was a sub-set of governance, then evaluated and considered the education required to address those areas while evaluating what impact this would have on practice and outcomes. The purpose of this process as explained in the education steering group terms of reference was to translate theory into measurable practice and performance outcomes, which the training model used in the care industry at the time did not cover well. I also noted that supervision and performance management of staff was encouraged through a mentorship and coaching approach, as opposed to a policy approach. The objective of this highlighted in the education policy was to transform the way managers supported staff who may be struggling to demonstrate excellence by assessing their competencies, skills and knowledge gaps; implement a supporting development plan for the staff member that would be monitored over a period of time; and empower the staff member to take ownership over making the changes required to improve their practice. The available learning resources provided the tools needed by the managers and staff involved, making it easy to agree on how the gaps would be filled as documented in the education steering group plans.

Through my literature review I note that there were indications of a similar model called 'teaching care homes'. While other organisations had adopted this mode since 2018, NH's CHEC model was different in that it provided education that would be formally accredited through City & Guilds, and offered CPD for all staff from Qualifications and Credit Framework (QCF) Levels 2–5; that is, diploma level. Furthermore, NH's education was tailored to support competencies, skills and empowerment of staff to become leaders. Secondary data shows that it was delivered by formally qualified educators and QCF assessors employed full time by the home. These educators and assessors were developed to become subject experts in the areas in

which they had delivered teaching in the previous two years. Although this project commenced early in 2016, it prioritised creating the learning environment by introducing research; commencing qualifications for the leaders who were going to support education with staff; and defining CPD pathways for their staff groups.

4.4 How NH Implemented Education in Practice

Having worked at NH I am aware of the fact that more than 80% of its residents having advanced dementia, an average age of admission of 92 years and complex advanced care needs, NH's focus was to develop a workforce that had proficient knowledge, skills, competencies and confidence to meet the associated care demands. As a charity with limited resources and funding, it had to be innovative and creative in designing an internal system that was cost effective and sustainable yet effective in empowering all levels of staff. Evidence of practice in NH's strategic planning and the education objectives reviewed during the research indicated NH focussed on completing a skills gaps analysis for its workforce and then reviewing the way in which it trained staff and introduced an education, coaching and mentorship approach. This changed its focus and delivery from classroom-based training, which assumed one learning style, to a tailored mixed model that included learning through case study, reflection, supervision and simulation. Earlier literature review suggested evidence that current learning in the industry is classroom based and focusses on compliance; where NH was taking a new approach to tailored education and training in specific roles, and staff gaps in three areas of interest (knowledge, skills and competences).

Further evidence from the literature review supports this approach and suggests that connecting theory and practice by modifying the way tailored training is delivered has proven effective in transforming practice as staff are comfortable to demonstrate and follow best practice. NH took this one step further by providing continuous development pathways for staff, which provided clarity for mentors, supervisors and staff in structuring support and providing the right support. Figure 4.4 is an extract from NH's education strategy that illustrates how the empowerment model was delivered through practice within the learning environment.



Figure 4.4: NH's education strategy Source: NH five-year strategic plan

The education policy outlined that core courses were categorised as the learning modules that every staff had to complete as part of their induction, to ensure they had the right knowledge and skills. Mandatory sessions were those that regulators (CQC and other related Commissioners) expected staff in the industry to attend. Elective sessions were additional advanced sessions to which staff could be referred to begin their development journey. Individual staff could also pick any subject of interest and complete the course. Practice development courses were more formal, accredited courses specific to specialist practice such as catheterisation, managing an outbreak or Levels 2–4 in Health Social Care. Competency-based courses were mainly for specific areas in which staff had to improve depending on the areas in which they worked. Examples from staff training records were catheterisation, phlebotomy, compression bandaging and syringe driver management. The NH strategic plan includes this category of education based on relevant clinical and medical care demands.

In accordance with the organisations own continuous practice development policies, focussing on developing its own staff to manage these concerns meant that NH reduced its reliance on the NHS or hospital specialist services, which were often too busy to respond to referrals for residents needing specialist care. Empowering its own staff to have specific skills and competencies related to the comorbidities of their residents improved health outcomes for residents who could be cared for immediately in the home without having to be transferred out. Section 1.1 of this thesis highlights that the industry faces problems with shortages of support for specialist services, which often results in delayed intervention, complaints and safeguarding issues. Evidence collected in this chapter states NH's final educational focus was skill-based courses that were offered to key staff such as leaders, mentors and clinical teams. These courses included becoming an educator, mentor, tissue viability specialist, infection control lead, EoLC lead and any other specialisation that the organisation needed to meet care demands or its strategic objectives.

Further evidence from the education policy highlighted the to build the appropriate educational resources and accessibility for staff to learn on the go, NH researched and introduced an online learning platform that allowed staff to learn through literature, video clips, pictographs and tests and assessments. NH is shown to have changed where and how people learn to consider different learning styles, preferences, learning on the job, research and reflection in practice. This learning education approach was then linked to supervision and objectives for staff to ensure they could demonstrate what was learnt, with the intention of evaluating changes in practice. Having worked in the industry, I am aware that most care homes have either an online learning platform or use a traditional classroom approach. NH in its design of the CHEC created a blended learning solution, which seems to have proved effective in transforming staff performance, as highlighted in CQC inspection reports.

I explored through secondary data collected to establish whether the changed learning methods and processes were the only factors contributing to improved standards. This was because the literature review argued that knowledge and competencies are not the only key drivers of high standards of care; rather, the evidence suggests that staff attitudes, behaviours and personal values also affect how they deliver care regardless of their level of knowledgeable or competence. I also considered explanation how NH had managed to maintain consistency in the improved standards over the three-year period despite being the largest single site care home in the UK. Industry assumptions are that large care homes should take a longer than that

view of the literature outcomes in chapter 2 which identify that only 1% of care homes were outstanding in CQC's 2019 publications of ratings. Understanding how NH had achieved this was crucial for this study as it would lead to suitable recommendations from this thesis in chapter six.

To that effect, I analysed policies and procedures covering all care aspects of NH (e.g. admissions, assessments, care plans, care reviews, staff development, staff equal opportunities and supervisions). All evidence reviewed highlighted that NH's aim to become a centre of excellence by building a team that delivered PCC through a focus on relationships between the staff, residents, relatives and multidisciplinary team was universal. While PCC was introduced prior to 2016, in 2018 NH had developed its new philosophy of relationship-centred care (RCC) to encompass PCC and support staff to better engage with all stakeholders.

According to the NH five-year strategic plan, governance minutes and the project implementation plan reviewed as part of this research, this RCC model was designed to support the learning environment by building a philosophy where all key stakeholders value each other and work as partners towards the same care goals. The model was also included to improve attitudes, values and other soft skills that cannot be addressed through education or training. However, there was strong recognition that RCC fundamentally influenced how care was delivered by staff as well as the experience of residents who in turn would provide feedback to determine standards of care. NH, having reviewed its complaint trends and incident reports, felt that a necessary component of its learning environment was to ensure that the care home presented an environment in which residents were comfortable and trusted staff. NH believed this would allow staff to listen and be more compassionate and considerate when responding to any changes in needs while applying their knowledge, skills and competencies to make the right intervention decisions.

To understand how each of its approaches worked, NH used research and participated in studies as a registered patient participation centre. This suggested it opened up to working with five universities where students and research partners used NH for field studies in subjects that the organisation wanted to explore. Examples seen during my data collection were research partnership projects on dementia care, the impact of using technology in care, EoLC and evaluating PCC in practice. Governance minutes I viewed between 2016 and 2020 also provided evidence for an active learning cycle where the organisation identified an issue from its trends analysis, engaged with managers and staff, agreed on a research topic and outcomes,

and then contacted universities to agree on the research questions and how research would be used to improve practice following a set of recommendations. These recommendations were then communicated back into practice through training, coaching, workshops and consultation with staff, where policies had to be modified to improve practice.

This inclusion of research in practice and education was further unique as most care homes did not have a research policy or focus in their strategic planning objectives. The way research was integrated into the learning cycles at NH enhanced staff opportunities to reflect, use case study and be up to date with information about best practice. The literature review findings support that change and transformation in practice requires a shift in organisational culture. This is a slow process, but successful change is accelerated when a non-threatening environment is created where members of a team can be challenged to think differently without feeling demotivated. Research participation is considered a useful way of allowing staff to explore questions and answers about their own practice and consider what evidence suggests is good practice. The literature review also found that this promotes a learning environment such as that which NH has managed to create.

NH's Five-year strategy outlines that research is integral to evaluating what works well and why it works well via an evidence-based approach. It also creates an environment where their staff can learn from researchers as they examine evidence and review outcomes together through case study. This encourages their staff to change the way they deliver care by taking a more philosophical rather than a task-oriented approach hence they have linked with universities to participate in studies and trials. NH provides placement opportunities to nursing, public health, speech and language therapists, occupational and physio therapists, PhD students, nursing associates, assistant practitioners and public health students. Placements of students stimulate debate, cross-learning and positive challenges to among as they interact with different types of student. This also stimulates staff to want to learn something new and be challenged on their practice, based on new evidence that students can bring to the work environment.

This contributes to the learning climate or environment, which allows staff to acquire and be open to new information in their practice. Such an environment supports a positive culture of learning through experience or mistakes, reflection on practice and willingness to change.

4.5 Summary

Primary data collected indicated that over a four year period between 2016-2020, NH's performance in terms of CQC standards, inspection ratings and KLOE outcomes had significantly improved from a rating of 'good' to one of 'outstanding'. This improvement was supported by secondary evidence highlighted in the inspection reports and internal quality assurance records at NH. The organisation's five-year strategic plan and KPIs highlighted that education and the environment where practice took place were a focus area it invested resources to transform the way education was delivered with an aim to improve staff knowledge, skills and competencies.

Both primary and secondary data for the period in which education had replaced training through the introduction of a learning environment confirms a positive impact on recruitment, retention, performance and care outcomes as defined by the KPIs. Stakeholder interviews provided detailed positive feedback about their observations and experience of the impact of a learning environment on standards of care at NH. The questions presented to them sought to understand the participants' personal and collective views on what constituted the learning environment at NH, lessons learnt, challenges faced, governance system, framework systems, challenges faced and whether a learning environment was something that could be replicated easily to benefit other care homes.

The findings from the primary data collected suggested that NH improved its performance directly as a result of introduction of a learning environment as part of the CHEC project. The transformational aspect of their learning environment is defined and consist of education, culture, research, leadership, and philosophy of care. These elements are driven through continuous practice and development of staff which starts with an individual skills analysis to identify gaps in knowledge, skills and competencies. Followed by an individual practice development plan tailored and supported through mentoring, coaching, reflective discussions, and formal and informal workshops. The education design indicated an improvement in staff's practice and ability to evidence outcomes related to KPI expectations both for NH and the CQC regulators. The principles underpinning education at NH are core competencies in PCC, RCC, dementia and EoLC care as the fundamental areas that require specialist practice, yet are those that most care homes struggle to meet in the industry.

The learning experience of staff is designed in such a way that there are learning opportunities on the job or in one's own time to maximise learning time. The use of resources such as the eLearning platform and practice workbooks provides a personal development journal for staff and helps transform theory into practical knowledge. Learning is also enhanced by the introduction of research in the organisation, which has helped to challenge the way care has been delivered in the past and facilitate a cultural shift in staff towards considering evidence-based practice in all care practices. The outcome of this is staff and leaders confident in making decisions in practice knowing that they are taking an approach proven to deliver the right care outcomes.

The partnerships established with research partners and universities also created an ecosystem where staff at NH benefit from learning indirectly from students conducting research. These in turn are also learning through their studies and conducting research, and both parties reflect on outcomes and findings that are then used to influence a change in practice. In line with research enhancing the learning environment, the introduction of student placement for different fields and disciplines in the community care specialisation also had a huge impact on how the learning environment became successful. Participants confirmed the benefits of cross-learning between university postgraduate, MSc, diploma and PhD students. My findings are that this close working together brought confidence and a sense of purpose for the staff at NH. Who ultimately became motivated to develop themselves and be part of the learning culture as they interact with various students coming from a similar background to their own or sharing their own positive experiences of learning.

The characteristics of the conceptual framework are that the learning environment is composed of a culture change cycle, continuous development of staff through education, developing leadership ethos in each staff regardless of role, research and demonstrating PCC and RCC through the values of the organisation. To achieve this and maintain a consistent state of learning, the framework's design to embed a philosophy of reflective practice for all MDT and use of case studies to evaluate outcomes of each activity or intervention. All participants highlighted that what made the learning environment at NH sustainable is the approach of linking education to all the policies and procedures that underpin practice and its governance systems. To ensure high standards or quality of education in a measurable way, an education and development subcommittee consisting of subject experts was developed to evaluate operational KPI outcomes and identify trends in the organisation. It then made

recommendations for change and improvements in matters related to learning objectives and outcomes for each quarter based on changing challenges and the need to adapt to new research and care approaches. This is suggested to have made the learning environment at NH flexible, adaptable and responsive to the needs of residents, relatives and workforce.

Participants identified the success of implementing a culture change in this learning environment as propagated by the performance management framework of induction, probation review, supervision and appraisal, which is used to disseminate and evaluate new knowledge, learning objectives and outcomes. All participants cited the advantages of this approach in that it provides a coordinated vision to ensure that all those involved were focussing on the same big picture in every training and course attended. They feedback that for NH to achieve this drive towards the same goal of excellence, it developed its own learning resources and workforce, which gives them the advantage of control and the ability to set standards of learning outcomes while retaining flexibility in being able to tailor each learning outcome to meet the changing needs and demands of the organisation.

The other advantage participants revealed is developing and using internal resources of educators and assessors that believe in the vision and values of the organisation. This point was critical in that internal resources were aligned and influenced the culture and philosophy of care practice. I noted throughout the interviews that staff reflected with surprise on their own improved practice and that of their colleagues or people they managed, in terms of the transformation they had seen since the introduction of the learning environment. They believe that having developed a superior education workforce with qualifications in AET ensured top quality of the support and education being delivered. They were aware how peculiar an approach taken by NH was compared to other care homes in the industry who only have ‘train the trainer’ qualifications, which means that a subject expert is trained on how to train other staff on a specific topic or subject. This is usually achieved in a two or three-day course but does not go into the detail of developing teaching and assessment skills, unlike the three-month AET course undertaken by the educators at NH.

My findings indicated that education at NH is not isolated to a single department. Rather, through the governance and quality assurance system, progress is monitored and evaluated through the use of audits, KPIs and customer feedback. The quality assurance process covers numerous surveys and communication channels such as meetings, incident reviews and

handovers. Participants pointed this out as the key driver in the success of creating a learning environment across the organisation.

My findings also identified that the introduction of the learning environment did, however, come with challenges and constraints. One such example is changing the culture of practice from a compliance approach in training to a more CPD approach through education. The main factor was leaders initially were not responsive in a suitable timeframe to consider innovative and creative ways to extend the financial and human resources required to support this learning environment process. The lack of response was due to a concern that a lot of new education was being introduced whilst trying to comply with mandatory training specifically expected by the regulators. This created stress on educators, assessors and budget holders. Participants suggested this could have been avoided had leaders been creative in mapping learning outcomes and similarities between the new education and old training modules then replaced the old training immediately without trying to blend or amalgamate them just to evidence compliance with CQC's expectations. This may have reduced the financial demand to increase the number of paid hours for both the learners (staff) and educators, instead of retaining the regulator training sessions and adding the new education, which meant that more education hours were required for both the mandatory and practice development sessions.

However, a contributing factor in this issue was that NH was operating in an environment that was heavily regulated by CQC and local authorities whose focus was training defined within their own standards expected of care homes. This was a constraint in creating a new learning pathway that was not solely focussed on staff attending single modules or sessions on particular subjects, as this was not enough to develop knowledge and skills. However it was necessary to demonstrate that staff had attended a session, completed it and were signed off, as required by the regulators.

Other challenges included the use of educators, assessors and subject experts who had other main roles and provided education only as a fraction of their employed time. Participants highlighted how challenging and stressful it was initially to try and meet the demand in the organisation for supporting education development of both existing and new staff required. Recommendations to recruit or re-allocate these staff into full-time education or assessor posts seemed to have made a big difference over time. Fundraising for specific roles and provision of a tailored financial budget dedicated to education and the CHEC managed to resolve the challenges once leaders had agreed on the best way to support the project. One of the most

challenging aspects of introducing a learning environment was that the concept was new and therefore most aspects had to be trialled and then reviewed to consider whether they had a positive or negative impact. It was difficult for the leadership team to reach consensus as there was no point of reference for the innovative ideas that were being discussed. This required much team cohesion and a professional attitude to get things moving.

Notwithstanding the issues raised, the feedback suggests that the process of implementing the learning environment was much smoother than expected and although some participants highlighted aspects that could have been undertaken differently, they all agreed on the success of the project. To that effect, there were no failures or ideas scrapped because they could not be implemented. It was noted that a point of reflection was that more workshops were needed to ensure that all staff were fully introduced to and understood the concept of a learning environment so that they could prepare for the changes being proposed.

Participants considered the viability of the learning environment at NH being replicated across the industry in other care homes. Their thoughts covered a number of ideas, some of which some are already in development and some that could be explored further. It can be concluded that NH could become a central hub for research, education and development of other leaders, care managers and organisations looking to implement the same project. This was reported by participants as already occurring at NH, which hosts many education workshops and tours for other homes ready to learn about dementia environment, practice and how to demonstrate high standards in PCC, RCC and EoLC. It was also noted that NH hosts international visitors who visit the organisation because of its reputation as a centre for good practice in the UK. There is further opportunity to consider key subject experts from NH to provide consultancy services to other providers who wish to undertake the same journey. Although this was also reported to have begun at a small scale, there are viable opportunities to develop this service at a much broader scale to meet demand in the industry. There is a possibility of NH publishing a step-by-step guide to developing a learning environment so that other care homes can adopt the concept and apply it individually. Further, NH could hold webinars, virtual workshops and virtual seminars on how to create a learning environment. In light of the current COVID-19 pandemic, this can easily be done online rather than via physical visits to the home.

The mainframe of a learning environment is replacing basic training with education, developing internal skills and competencies by having qualified educators and assessors and then considering a learning library tailored to the home's needs. Implementation is affordable

by replacing the outsourcing of trainers and sending staff to attend certain training outside the home for which they are charged. The viability and cost benefit of investing in a learning environment is that staff turnover, sickness, absence and recruitment improves significantly. These cost savings outweigh the initial investment cost. NH has been able to demonstrate this through the improvement of KPIs for staff management, according to the secondary data collected from its governance outcome measures. Its performance also supports this improvement as evidenced through its CQC 'outstanding' rating.

Chapter 5: Analysis and Discussion

5.1 Introduction

This chapter takes the findings from the previous chapters and analyses them according to the research design and methodology outlined in my research methodology section. This analysis is followed by a brief summary concerning the stakeholders and what has been learnt from them through the findings. This acts as a ‘re-cap’ for the following discussions. The latter comprises reflections on the theory and literature, based on the information gathered in chapter 3 and 4. Then, a brief discussion is provided concerning commonalities and differences between the approach NH took and what is suggested in literature review regarding learning and its impact on workforce in care homes. This sets the theoretical material within a pragmatic context. Then, the chapter returns to a more theoretical perspective by showing how the notion of introducing a learning environment has an impact on the quality of care in a nursing home. The improvements in workforce development and quality of care delivered can be used to reconceptualise the notion of improved outcomes and performance of the organisation and how it interconnects to the known standards. The chapter concludes with some implications that follow from the analysis and discussion.

5.2 Analysis of Literature Review

Literature review has been expedient in defining learning as a concept and further highlighting the most important forms that contribute to a learning environment. It outlines cognitive learning as the first form that is most relevant to changing practice. The evidence analysed supports that learners are facilitated to engage actively in constructing thought processes and using memory to retain information that relates to certain steps to accomplish or achieve certain outcomes. This has also been proved through debates between different scholars that having knowledge and skills will lead to better outcomes when appropriate assessments are completed to capture all the critical details that affect the wellbeing of the resident. Having worked in the industry myself and considering frailty levels of residents being admitted in care homes and how complex their care needs are, this stage of admission process is critical in preventing

residents from ending up in hospital if their care needs are not adequately planned for or deteriorating soon after admission to the home leading to complaints. Literature review seems to offer a practical and applicable approach to learning which addresses that problem within care homes as outlined in chapter 1.

The second type of learning literature analysis has considered relevant to care homes is conditioning and association. Evidence provided supports this process to involve staff learning how to analyse and associate certain data and activities in practice then takes decisive action from anticipating potential outcomes. Analysing how this applies in practice, an example is staff assessing a residents' clinical and medical observations and anticipating what could to the resident. Therefore automatically triggering action to administer medication without delay and immediately instigating a referral to the appropriate multidisciplinary team. Literature review is suggesting that prompt and accurate interventions through conditioning and association will avoid delays in care intervention, thereby preventing deterioration or neglect of care. I would agree with literature reviews findings that if the industry adopted this learning model in practice, this could provide beneficial outcomes and transform how staff are developed to improve their confidence and sustain high performance and outcomes. Instead of the current practice as highlighted in chapter 2 stating that the care industry currently focusses on training that fails to embed information in the understanding of staff to change the way the learner or staff member views and engages with their roles and responsibilities.

The evidence so far provided in literature review supports that for learning to be effective, there has to be conducive learning environment. I did however find there is limited research and information available to define a learning environment within a care home setting. Nevertheless, analysis of available definitions in alternative industries provided adequately adopted learning environment principles for the care homes. Achieved through conceptualising examples that can be transferred from an academic environment to a care home environment, whereby staff are considered learners for the purposes of applying knowledge, skills and competencies. My deduction from this is that a learning environment is an educational setting with a cultural context where teaching and learning takes place. I also analysed other suitable definitions offered through literature review such as that a learning environment is any place where education is delivered with an emphasis on the cultural context that underpins the teaching in a specific physical environment. From those similar definitions and points of view, literature review alluded to the fact that regardless of industry differences, teaching should be

adopted and applied as a better approach that is different from the current industry practice of training staff. Furthermore, it embraces the cultural ethos of the establishment in terms of how each individual learner is supported and developed to meet their learning needs. That point is however immediately quantified by literature in that governance and policies must be in place to facilitate this process, and ensuring that the necessary resources are made available to both the learner and teacher is critical.

Additional analysis of literature review explains how organisational culture being conducive to learning by instilling a philosophy creates a positive, nurturing and safe experience for the learner to question, challenge and connect with both teachers and the context being applied. I can see how an approach of integrating organisational philosophy, culture and processes establishes a learning environment as literature review defines in the educational institutions where students learn and develop knowledge and understanding. Literature review added that whilst this concept and framework is structured and purposed for the classroom setting, it does offer a number of critical features that can be applied to the learning concept in the care home industry. Analysing evidence gathered in literature review, I find there are enough commonalities highlighted in literature review between the education industry (classroom setting) and care home industry (workplace) environment such as the need for a philosophy and positive culture of learning within the organisation.

Another critical point literature analysis uncovered relates to the governance of the organisation in evaluating and reviewing how learning is conducted or experienced by learners in line with regulations and other performance indicators linked to the environment. This process is defined in chapter 2 by policies, processes and procedures that outline the learning objectives and how to deliver these to learners, in this case staff. In this case, this would be the CQC's fundamental standards and regulations relating to staff development and training outcomes. To achieve this, literature analysis identifies a solution for specific resources to ensure the correct education is delivered by appropriately skilled educators and there is access to the necessary learning material by all students or staff.

Literature review explored that within the health care industry, this would involve ensuring that these educators delivering sessions to staff have the appropriate qualifications and experience to ensure learning characterised by knowledge and understanding is achieved. Analysing literature review, current practice within the care home industry where education is defined by provision of one-hour training sessions in which information is disseminated to staff and

handouts perhaps provided as part of mandatory annual sessions is wholly inadequate. This does not match any other characteristics of the learning processes or environments in the education industry which have been suggested as more proficient. One explanation from reviewing evidence gathered is that training is conducted this way to accommodate staff with limited amount of time to learn because of the demanding nature of their work. Therefore education is not made a priority over care as it should. Another notion is that the financial resources in most care homes working with tight training budgets are insufficient to expand on learning resources and processes to make them similar to those in the education system.

However, there are some practical concepts literature review has proposed that can be adopted to enhance learning by creating an environment that is conducive for staff to develop knowledge and better understanding through cultural change at organisational and leadership levels as outlined in the next discussion.

First, creating an environment in which staff are encouraged to question things allows learning to start taking place through reflections on the responses, possibilities and opportunities that come with answers to questions they may have regarding care. Secondly, creating a learning environment is establishing an attitude of positivity and empowering staff to grow and develop within their own role. This is understood to bring about self-motivation and enthusiasm to participate in change and improvement, and sharing of common goal with other team members. It is established through literature review that benefits of this include better team collaboration and working together. Which is considered to resulting improved outcomes. It is also established in literature review that outlining clear expectations that define high standards is part of creating a learning environment as this creates a vision and goal for staff to aim towards as they go through their development journey.

Thirdly, literature review elaborated that developing a learning environment also involves establishing a range of opportunities structured to provide different learning experiences. This encompasses different learning material and resources to facilitate learning. Traditionally, in the UK care industry, training occurs face to face via a trainer in a classroom setting. Some organisations are developing information technology (IT) capabilities and their staff are now able to access computers and eLearning. The concept of a comprehensive learning experience is that different learning styles require different approaches to accessing information; achieving this requires provision of a number of learning resources which include reading materials, publications and literature, as well as short video clips that staff can watch and audio clips that

those who learn more from listening can access and listen to any time. It is also suggested that the teaching should include some face-to-face sessions to provide interactive engagement between staff and educators; personal reflective time for individual introspective analysis; self-assessment; opportunities for staff to engage in groups to brainstorm or discuss ideas; and one-to-one sessions either with educators or assessors to review the learning process. It has also been established that supervisions and appraisals form an integral part of transferring theoretical knowledge into practical knowledge through skills and competency reviews.

Additionally, fundamental parts of learning discussed in literature review is that information disseminated to staff should be evidence based and relevant to the skills and competencies they are required to demonstrate to meet the standards expected in delivering care. The way knowledge and information can be kept up to date and relevant is suggested through research and linking findings to learning objectives. Research has been lacking in the care home industry until very recently. The biggest challenge has been a lack of interest from care home managers to allow researchers to come in and work with residents or staff. This may have been for any number of reasons including a lack of understanding in terms of research values, processes and application. However, the literature review has indicated that for education to be most relevant and applicable to changing trends, attitudes and care processes, research plays a vital part in ensuring best practice that is up to date. Another important aspect of research is that it provides staff with an opportunity to learn from other professionals whose mentality and approach to learning may be different, by way of challenging normal practice and a philosophy of evaluating practice. These skills are part of what constitutes a good learning environment.

Literature review suggested that for staff to remain motivated, and engaged in learning and developing their knowledge, skills and competencies, the learning environment should include clear milestones to mark progress and celebrate achievements at different stages of the development journey. This is considered critical in not only acknowledging the efforts of each staff member but also placing emphasis on the organisation's expectation that each staff member should be improving themselves and their practice in a measurable way. There are a number of ways in which this is achieved in other settings, including certificates of achievement or attendance for each completed course, module or unit. Other considerations could be acknowledgment letters signed by the leadership team or managers who head the relevant departments in which staff are working. Incentives could also be celebration and graduation parties to highlight achievements, synonymous with education institutions such as

colleges and universities. The significance of having such processes is to provide an end date to each learning period and give staff something to work towards and a positive outlook for something they can enjoy.

Literature review highlighted that the final part of a learning environment is creating platforms, attitudes and opportunities for case study-reflective discussion and feedback. This is considered a necessary way to encourage staff to critically analyse situations in which things may have not gone well and to critically think about and reflect on what could have been done differently—while considering what went wrong and why—as this will create a learning cycle from the incident that allows them to independently identify how to manage a similar situation if it arises again in their practice. This process is considered to have a huge impact on learning as it pushes staff to develop skills in critical thinking, which are believed to be the beginning of transformational practice that leads to better outcomes in terms of performance.

5.3 A Stage Analysis of Learning at NH

The literature review identified that learning occurs when staff are supported through teaching to develop knowledge and understanding of relevant information that will help to change their attitudes, practice and behaviour, according to De Hovwer et al. (2013). Comparing this definition with the current approach at NH following the introduction of the CHEC as part of the learning environment reveals similarities in application. Furthermore, supported by secondary data collected and analysed indicating that NH's philosophy for education is built on engaging with its staff to assess their knowledge gaps and empower them to develop understanding and apply knowledge in practice. This is reinforced by primary data collected through interviews with stakeholder participants, who confirmed that learning at NH is based on teaching principles where staff feel enabled by the organisation to translate what they have learnt into practice. Analysing this evidence against industry practice shows that NH's practice is contrary to findings from the literature review in relation to the wider industry, which seems to provide only training to staff with no process for empowering understanding to become knowledge in practice.

In terms of the definition of learning, the literature review highlighted that learning should include knowledge, skills and competencies that are measurable. A number of arguments were

presented in Chapter 4 about why and how this is paramount to ensure that the process of learning is complete. Reflecting on NH's new model of education under the CHEC, evidence from secondary data collected highlights that it introduced a skills gap analysis process for staff linked to their CPD programme. These similarities in approach indicate the importance of teaching that includes outcomes that relate to knowledge, skills and competencies, as the findings in Chapter 4 provide evidence that once NH had met these outcomes its staff's performance began to improve. This observation was confirmed by interviewees who stated that they were now more confident not only in their knowledge, but also in skills and competencies.

While the literature review did not reveal a standardised competency assessment or outcome framework for staff working in care homes, it did highlight that these should be made relevant to the challenges and care needs of the organisation. According to secondary data collected for NH, it developed its own competency assessments and outcomes in relation to the standards of care and KPIs it wanted to improve. This was confirmed by interview participants who stated that they had seen improvements in staff competencies in areas such as medication, syringe driver management, care planning, wound dressing management, ascetic techniques, falls assessment and a number of other key outcomes for both new staff being inducted and clinical staff who required periodic reviews.

The literature review considered Chaiter et al.'s (2014) framework instrumental in enabling learning to take place. There was evidence of an organisational structure at NH with governance systems for learning implementation and review of policies and procedures tailored to support learning within the environment. Secondary data collected and reviewed in relation to the learning environment at NH showed a clear vision is outlined in all its policies and procedures to empower staff through education to enable PCC to be delivered effectively as part of becoming a centre of excellence. Secondary data also explored NH's education, equal opportunity and staff development policies, which are aligned to their vision and detail the link with continuous development programmes. It was also highlighted in Chapter 4 how NH's education and development governance system oversees the education process across the organisation and uses trends analysis to make decisions on what education is required to improve areas that are underperforming within care. This evidence was corroborated by feedback during interviews with educators, mentors and assessors who outlined the various policies they have to follow when delivering education and supporting staff in practice.

Evidence from the literature review highlighted that learning environments are effective if they consider the different learning styles of staff as part of their design. NH's CHEC model was found to demonstrate a learning environment and approach where learners can access education through eLearning, videos, audio, face to face, reading literature, observations and participating in practical sessions. Participants mentioned the availability of different learning methods and commented on how staff attitudes towards learning positively changed when these options were made available. They confirmed that they felt empowered and motivated and had begun to enjoy learning.

Stakeholder participants' evidence also concurred with the literature review in that some staff who may have struggled before seemed to no longer have challenges as they engaged better with the various learning methods. There seems a strong link between the literature review suggestions and the experience of staff at NH in relation to provision of different methods of learning to capture different learning style needs. One aspect not explored in the literature review was whether it was imperative to assess the learning styles of learners to allocate or signpost them to the most relevant learning interventions. At NH, participants seemed to be suggesting that staff engaged in all options at different levels and this contributed to their overall positive experience of improving understanding.

Biesta (2018) emphasises that successful learning environments must offer access to a wide variety of learning resources to enable staff to obtain information when they need it. It was suggested that this is crucial in building their confidence when dealing with clinical and medical care issues in practice. NH extended its learning resources with the introduction of the CHEC by creating a learning resource centre within the organisation. This space is available to staff anytime to read, research or access eLearning platforms via workstations. The organisation also introduced an electronic care management system with an integrated learning library enabling staff can access policies, procedures and video clips on any subject in the library while on the go. Secondary data collected also highlighted resources such as learning equipment used in practice and nursing manikins for practical sessions such as fire evacuation, first aid, basic life support, syringe driver management and general observations.

The literature review did not reveal exactly what resources are needed in the care home industry as there has been limited research in this area. However, staff who had participated in education programmes at NH revealed during interview that the current provisions mentioned improved staff attitudes towards learning, especially when eLearning and other options were introduced.

Participants confirmed the literature review findings that staff would feel more confident and in control of their learning, and that easy access to material at a time of their convenience would make learning less structured and more flexible to fit in with their busy schedules. This was an important finding that covers a gap in the literature relating to aspects of time as a critical resource for learning or its environment.

While this gap may be largely due to lack of direct research in care homes, the current study acknowledges the participants' reflections that prior to the introduction of the CHEC, training was structured and difficult to attend as the main option was to attend a classroom session; handouts were not readily available and sessions had to be pre-booked for one to attend. Since the introduction of eLearning, staff could attend sessions anytime, even at home. The literature review findings confirm that when staff are not fully engaged, the culture of training becomes more task oriented and less stimulating, which will impact on their ability to translate the knowledge into understanding and practice.

5.4 Learning/Skills Policy at NH

Illier (2018) identifies in literature review that a framework for learning is important to establish what knowledge, skills and competencies are required in an organisation based on the business it delivers. NH developed the empowerment model, which is described as a learning journey from induction to appraisal. The framework's approach is to define the skills required for each care role and identify who and how they might be developed to meet those outcomes. The use of a framework was evidenced through NH's mission statement in which it aims to use dedicated and experienced staff to deliver good care. While this signals intent, the secondary data collected indicated that NH has also invested in developing educational competencies to assess, deliver and evaluate these skills by introducing qualified educators and assessors who are subject experts in each of the targeted skills as defined by the KPIs for the organisation. The literature review emphasised that for skills to be developed, there needs to a combination of formal and informal education.

The evidence from stakeholder interviews detailed how the course structure at NH was designed for the CHEC implementation is supported by recommendations made by De Hovwer et al. (2013) regarding formal and informal learning approaches being relevant to support skills development. It was evidenced through the interviews with stakeholders that learning involved staff having to attend workshops, face-to-face sessions and some eLearning. Furthermore,

stakeholders provided evidence that they learnt through coaching, mentorship, assessments, observations and other less structured systems such as reflective meetings, tool box exercise and handover once CHEC was introduced at NH. This approach is supported and recommended in the literature to be effective in building skills and competencies. Furthermore, it has been proven to lead to positive results, according to both stakeholder participants who attended training at NH and those who provided the education, all of whom had seen a change in performance of staff across the organisation.

Another aspect of the contemporary learning environment revealed in literature review is the focus on outcomes that are measurable. However, the literature does not offer any suggestions on details for how this can be done effectively. The contemporary learning environment that was the focus of the literature review was that in other industries such as education and business. Nevertheless, evidence from stakeholder participants who answered questions about the impact of the learning environment on NH's standards of care showed that use of qualified subject experts to deliver specific courses such as EoLC, Tissue Viability Nurse (TVN) and medication management made a significant difference in how staff understood and applied the learning in practice to improve skills. These stakeholders further believed that the use of accredited educators, mentors and assessors to support both the theory, practical formal and informal learning created a perfect environment that maximised staff potential to translate knowledge and understanding into measurable skills and outcomes via KPIs.

5.5 Connectivity and Access to Learning

The literature review revealed that a learning environment is achieved when staff have access to learning and opportunities to apply this in practice to gain understanding in different contexts. Review of secondary data collected with reference to NH's educational policies and procedures provided evidence that NH's organisational mission is to deliver PCC through the empowerment of dedicated and skilled staff. Its values include teamwork and excellence as the key focus to ensure that everyone in the organisation is empowered to deliver appropriate standards of practice by educating them to develop the right knowledge, skills and competencies. The introduction of the CHEC established a process by which education is accessed for that mission to be achieved. Provision of resources such as a learning environment, eLearning platforms and libraries, workshops and reflective sessions went a long way to ensuring access to learning resources for all NH's workforce.

Secondary data collected also highlighted NH's vision to become an education centre. As established in Chapter 4, it has connected with universities to support its academic education and research network, which it also considers part of the learning environment. The strategy of providing student placements between NH and these universities has produced some transformational outcomes as learning has extended from simply the traditional routes of reading, attending courses and observations to cross-fertilisation of information from students, researchers and staff working at NH. This phenomenon was not apparent in the literature as its mainframe consists of a unique setup that exists only in care homes that are pioneering this model of care and education as part of their business, aside from just providing care, and NH is the first CHEC in Europe, Asia and the United States of America. Participants interviewed as part of this research confirmed that the learning environment at NH has provided them an outstanding experience where learning is formal, informal, directed and filtered through practice and interaction with other professionals, students and researchers.

Stakeholder participants also stated how this had improved their confidence, generated interest in acquiring further learning and changed their culture of practice as they felt the organisation is now of a high standard because of its academic affiliation through the implementation of a learning environment. Although the literature review did find evidence that association and conditioning are other important types of learning that can be implemented, there is no evidence in the literature of the phenomenon identified by participants that association with academics and professionals can change culture and attitudes to promote a positive approach to learning. Further, the integration of students and researchers creates a learning platform where cross-fertilisation of information, best practice and academic knowledge is experienced by staff with an outcome of improved understanding.

A well-known phenomenon is that students attend work placements to learn; the opposite situation, where they end up teaching staff who in turn are also teaching them is not so well known. This had clearly been the experience of the participants, who stated that they had seen care staff taking ownership and beginning to teach students while also benefitting from what students had to share. And an occurrence where staff offer practical skills and students trade their theoretical knowledge. Both groups end up developing competencies in practice with evidence-based outcomes as this process includes reflecting on why they do things the way they do and whether it is the best approach. The literature review highlighted a strong link between reflective learning and improved practice outcomes. The environment at NH is

providing an enhanced space for this to happen with different partners, which improves what staff learn and yet gives them control over how to apply it in their practice.

5.6 Learning and Continuous Practice Development

The literature review identified that learning is continuous and in practice is best approached through a staged yet continuous process that considers different learning styles and leads to improved practice competencies, according to Illier (2018). This is confirmed by other scholars such as Biesta (2018), who recommends a CPD plan that progresses learning for individuals to develop career-furthering skills, knowledge and competencies that are career changing. NH's education development plan, as explored through secondary data collected in Chapter 4, highlights its CHEC model, which is built on an individual (CPD) framework of identifying potential, knowledge and skills gaps, and then creating a plan that includes accredited formal and informal learning for all staff. It is underpinned by a defined career pathway within the organisation, which is evident in the way the organisational structure has evolved since the introduction of a learning environment. Evidence from secondary data showed that NH had introduced a number of new roles in the previous four years to support CPD and its CHEC model.

What is remarkable in NH's framework for recruitment and personal development is that 98% of these roles were filled by existing staff who were supported internally as part of their career development. Examples include the education and development manager, PCC champions, RCC champions, TVN specialist nurse, care manager (responsible for infection control and first aid, Cardiac Pulmonary Resuscitation and Basic Life Support education). Other key staff were mental capacity and deprivation of liberty lead, assistant practitioner, care quality improvement lead, educators, assessors, mentors, dietetic practitioner, and therapy technicians.

The literature review concluded that learning can be achieved through teaching that is associated with supporting, coaching and mentoring; rather than simply training staff, as suggested by De Hovwer et al. (2013). NH's approach to creating these new roles was not intended only to provide extra specialisation from formally qualified staff to meet complex care needs, but was designed to provide education, support, coaching, mentoring and quality assurance in relation to the education and development of staff. The literature review concluded that a positive learning environment is achieved when staff are evidenced to be confident, creative and autonomous in seeking ways in which they can improve themselves as well as

their performance. Evidence from the secondary data collected also highlighted that these new roles became part of the NH organisational structure, thereby establishing a career development pathway for other staff who aspired to these roles. Some interviewees stated that they had begun as carers and become qualified nurses with a speciality within the organisation. Others shared their personal experience of development and how they were now managers and educators, having started as carers.

An analysis of NH's HR processes indicated its staff development process included active succession planning for each role. The literature review suggested that development of staff needs to be continuous and lead to outcomes that staff can measure and perceive benefits to themselves. In that sense, NH's model of CHEC means that more staff are being supported to develop the skills, knowledge and competencies required to replace staff taking on those new roles and other leadership positions in the organisation. Evidence from the stakeholder interviews strongly supported the secondary data collected as well as the literature review evidence on this point. Participants stated that one outcome from this approach was that staff felt motivated to participate in CPD education so that they could better themselves, especially when they could relate to the opportunities and prospects of better career outcomes not just within the organisation, but elsewhere in the industry.

Chapter 1 identified some of the challenges faced in the industry as recruitment, retention, turnover and attitudes of staff within their roles. The evidence analysed in Chapter 4 regarding NH's career development focus as part of empowering its staff addressed these issues, as it had seen improved KPI performance in those areas over the previous three to four years. The literature does highlight the advantages of supporting and developing staff, as indicated by Skills for Care (2018) to include better performance in their role. However, literature does not go further to provide an analysis of the impact of developing staff in terms of their attitudes, culture and personal motivation, commitment to further learning connected to CPD process which leads to skills and competencies. Feedback from stakeholder group interviews at NH suggests that such impact is based on individuals being able to see a future for themselves in the organisation, and feel that they are part of the bigger picture and vision, while being able to appreciate their personal contributions towards that bigger picture.

This change in psychology and attitude goes beyond what is suggested in the literature in terms of the benefits of CPD in organisations and learning environments. Such transformation occurs at cultural and psychosocial levels, resulting in loyalty to the organisation, team and mentors

that believe and invest in the individual staff member. While more evidence is required in relation to this phenomenon, the literature review together with primary and secondary data analysis agree on the point that CPD needs to have a structured approach that is consistent and measurable for individuals to participate and benefit from it.

The literature review failed to uncover relevant studies defining how a measurable and consistent CPD process could be achieved in the care home industry as research in the area has been limited. The evidence from other environments is also not sufficiently specific to assist in conceptualising what kind of CPD process is transformational to career progression. NH is one of the first care homes to implement such a CHEC model with linked professional qualifications that are transferable across not only the health care industry but any industry, as it offers formal qualifications accredited under City & Guilds, offering a measurable and consistent CPD opportunity for staff. The most impactful evidence in regard to how the CPD was developed and implemented comes from the primary data collected through stakeholder interviews at NH. It was confirmed that staff were assessed and supported into formal education where they achieved diplomas, undergraduate degrees and MSc qualifications specific to areas of speciality in which they were progressing at NH. However, further research is required to provide an understanding of the extent to which the benefits extend the future career development of staff beyond the CHEC, as the literature review did not find evidence that could be used.

5.7 Extent of Learning in the Health Care Industry

I found this section regarding the extent of learning and training in the health care industry challenging to write because of the fact that the concept of creating a learning environment in a care home setting is new in the industry. Chapter 2 has highlighted that there is no research available on this topic specifically within care homes. There is evidence in the literature of an ongoing compliance focus in the care industry. Training is designed around the fundamental standards set by CQC as the regulator, hence most care homes provide only that specific training to comply with regulations. There is no enforceable requirement for any care home to provide more education or training beyond the regulatory requirements for mandatory training, which is provided only annually as a refresher for learners. There is no requirement for competencies to be assessed or evidenced after or during the year because there is no standardised learning outcomes, competency or education framework for care staff or nurses.

Apart from the mandatory training outlines by CQC, each care provider is free to offer whatever training it feels is adequate to meet its own challenges and demands. The literature review highlighted this as an issue because staff who are underdeveloped will underperform and become demotivated, with a range of negative consequences including staff turnover. Skills for Care has responsibility to support and provide guidance on good practice in the industry nationally; however, it does not have regulatory powers to enforce its recommendations, and care homes do not have to use the materials it provides. Chapters one and two have identified that the absence of collaborative structure, standards and framework in the industry is one of the main reasons for workforce development being so poor, resulting in many cases with care standards not being met.

Notwithstanding the above issues, the literature review did manage to explore some of the approaches and practices adopted by care homes in the industry. The review focussed on research conducted by Skills for Care (2016) on challenges faced by the industry, current processes, and if and how they contribute to workforce development. The first important point raised was that research defines learning as a composition of knowledge, skills and competencies. However, the scope of the literature review was limited to defining skills and competencies that are necessary to improve performance.

Scholars such as Chaiter et al. (2014) disagree with the idea that education should be delivered through teaching, which is a more skilled process of identifying needs and considering appropriate interventions and learning styles that will improve a person's outcomes over time. They suggest that training is short term and specific to learning objectives related to the specific content being delivered. In light of the stakeholder data collected through interview and the secondary data presented in Chapter 4, NH's approach reflects these scholars' comments that training is not effective.

What is also clear from the literature review and comparison of findings from the NH case study is that NH has taken a different approach from the rest of the industry. It introduced education through the CHEC model and replaced training. Evidence from its vision and mission statements also indicates that they are focussed on teaching and not delivering training; hence its investment in supporting staff to complete adult teaching qualifications and remodelling how education is delivered through multiple learning options. However, the literature review did not cover learning in the health care industry; it only highlighted the impact of education and teaching as it currently exists in the business and education industries.

The literature review findings also made it clear that there are no evidenced results available to evidence the impact of taking a learning approach, as in the case of NH. The success of its approach was evidenced through the stakeholder participants' interviews, which indicated that it had transformed the way information was received, understood and applied in practice. This evidence has been highlighted throughout Chapters 3–5. Further evidence that NH's approach did change practice outcomes came from the secondary data collected regarding KPIs, CQC reports and internal audits viewed during the research, which indicated positive trends in improved performance since introduction of the CHEC. This represents the first instance in the industry of a care home adopting a model of teaching and learning from a different industry and developing it into a model of care to come up with the CHEC. Further research over time is required to examine the different parts of this model and how it performs when applied in settings other than NH.

5.7.1 Impact of Learning on Stakeholder Groups

The literature review identified the expectation that where education is delivered in a learning environment, there should be positive results. However, this has not been the usual process in the care industry, which has always provided training. Initially it was not clear what the direct impact of learning on stakeholders would be, given a learning environment concept is a completely new experience in the industry. Chapter 4 detailed the impact of creating a learning environment and identified the key points illustrated in Figure 5.1.

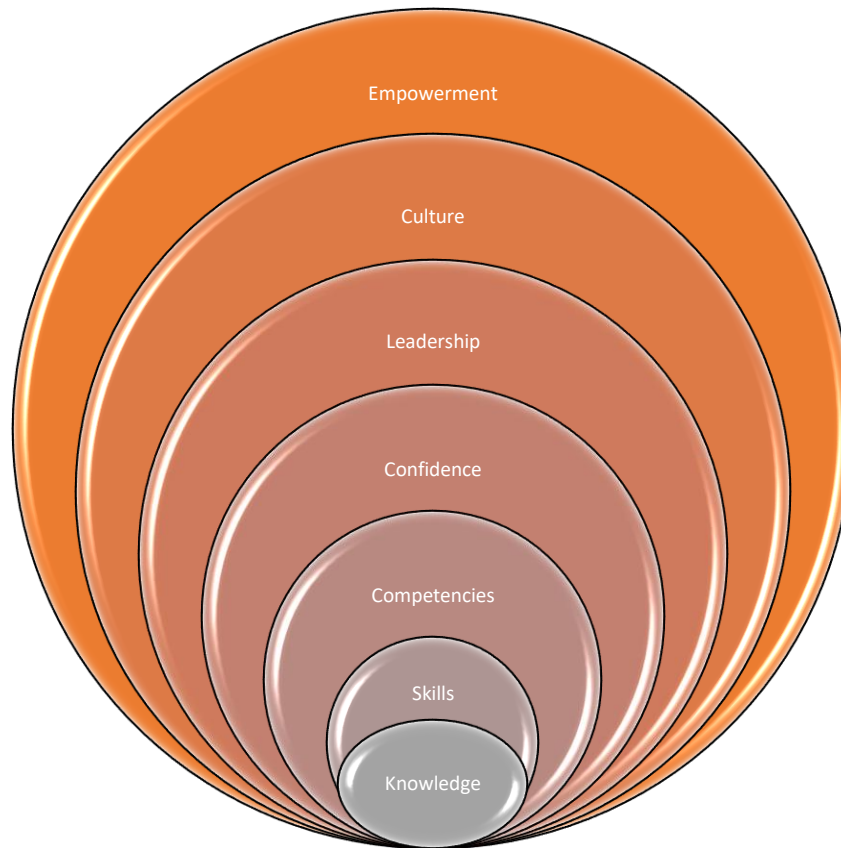


Figure 5.1: Impact of learning on stakeholder groups Source: created by Author (2020)

Feedback from participants was that they had increased in knowledge and understanding not only of the subjects related to their role, but also the policies, procedures and philosophies of care introduced as part of the education. Some participants stated that they had also earned academic qualifications through the formal education NH had begun to offer; that is, from Care Certificate Level 2 through to City & Guilds Level 5 in Adult Social Care. The literature review identified that the process of transforming care begins with identifying the learning information and content that can be built into knowledge relevant to care needs. NH did this by introducing a platform offering 200 courses and developing its own tailored courses to bridge gaps not covered in the learning objectives and outcomes from the learning library. Participants talked about incremental knowledge over time, which was also connected to their continuous practice and professional development. This suggested permanent acquisition of knowledge that fits with the literature review findings in relation to use of a staged approach to ensure that knowledge is built over time to sustain understanding that is considered learning, as opposed to training where people may remember things but not necessarily understand them.

Stakeholders identified that their skills had improved considerably. They cited examples such as in EoLC, TVN, care planning and research that evidences best practice, and many more areas in which they felt they had mastered the practice. The literature review suggested that for skills to be developed, a learning environment needs to provide an opportunity for staff to practice, make mistakes and reflect on how they could improve. Scholars suggest this can only be achieved if the organisation does not just focus on KPIs established by regulators as this creates a compliance focus that does not foster encouragement of staff to apply their knowledge to enhance practice. NH's learning approach included specific objectives set for each individual from induction through to annual appraisal. Those objectives included skills relevant to their posts that were evaluated or assessed at each review point. This approach encouraged staff to know what to concentrate on over time as part of their SMART objectives. It also facilitated managers and supervisors in considering what type of support was required for each staff member to meet their objectives and demonstrate them proficiently in practice.

Chaiter et al. (2014) state that the use of periodic supervision to review and follow progress of staff sets appropriate expectations about what standards staff need to achieve before they can be signed off. They also suggest that it creates an opportunity for the supervisor and supervisee to work together as partners to create an intervention plan that will lead to successful transformation of knowledge into skills through clearly defined objectives. The literature analysis suggested that an absence of such a framework leads to training that is not going to be effective for either the organisation, manager or staff as it wastes time if there are no SMART objectives and no way to evidence whether the staff are receiving the right support or aiming for the right outcomes. Stakeholders at NH stated that having a clear supervision process linked to their role and practice development encouraged learning. Most importantly, the two-monthly supervisions with their managers ensured they were aligned with the organisation's vision and journey, which enhanced their involvement and motivation to participate in that bigger picture.

Stakeholders identified improved competence in practice. Some had backgrounds as nurses and stated how their clinical competence had greatly improved following skills development that allowed them to exercise autonomy through best practice and research to consider the best way of delivering certain interventions. They stated that the combination of practice sessions, observations and a competency assessment framework allowed the learning attitude to change as staff identified that they had to go through a process of learning and be assessed to be competent at the end of it. This changed their own views of learning as they felt in control and

had ownership in their own development. Nurses talked about proficiency in phlebotomy, syringe driver management and other tasks that in other care homes would only be performed by advanced nurse practitioners from the GP—not because of a registration requirement but because most nurses in care homes have not developed such skills.

Literature review also indicated that a learning environment that is effective will invest in and provide opportunities for learning and practising certain interventions that require a level of proficiency to deliver high-standard outcomes. It also suggested this cannot be achieved without a competency framework that identifies what skills are needed for each staff level and a clearly defined route to support, develop and assess these competencies. While NH had defined competence outcomes, it also invested in assessors who could follow up and provide the assessments. The literature review revealed that this is not a common approach in the industry. Most providers either outsource assessments to consultants who come only to complete a specific assessment when staff are thought to be ready to demonstrate proficiency. However this is considered less effective compared to NH's approach as it means that external assessors are only involved in the learning and development of staff at an end point; failed assessments will result in staff feeling discouraged and not having enough time or support to identify how they could improve if the assessor is only present for the assessment itself.

The literature review also indicated that most care homes have no competency framework to begin with. Francis (2012) identifies that a lack of competencies is a major contributing factor to poor care outcomes, increases in safeguarding clinical concerns and unnecessary hospital admissions when care home staff fail to identify and intervene appropriately in the event of a deteriorating resident. One of the key areas for improvement identified by the NH stakeholders was improvement in dementia care. Given that on average 85% of residents at NH have cognitive impairment and of those, 40% have advanced dementia, this is an area where competence in assessing, preventing and managing changed behaviour is critical in improving quality of life. Stakeholder feedback suggested that it was possible to improve competencies once the education and learning outcomes had been linked to the competency framework, which was evaluated by suitably qualified assessors, educators and managers.

Stakeholders stated that they saw an increase in staff confidence overall across all departments and levels. As Figure 5.1 illustrates, confidence as one of the positive outcomes reported to have improved following the embedding of knowledge, support for skills development and competence outcomes. It was reported that care staff were able to support care plans, participate

in MDT meetings and teaching of new staff, and engage with residents. There was also confirmation of care staff improving confidence in assessing and identifying simple factors such as dehydration, possible UTI and delirium, which made a difference to the speed at which interventions could be put in place to improve the situation before it got worse. This was also evidenced in NH's KPIs where admission rates, pressure ulcers, UTIs and other clinical indicators were significantly lower than these rates in care homes less than half their size. Mainly because trying effectively and consistently manage multiple complex commodities for almost two hundred residents requires a larger, skilled, competent and confident workforce who can make clinical and care decisions autonomously whilst working with a much larger team compared to a small home which may only have fifty residents.

Stakeholders also shared that confidence in care staff being able to respond to simple matters relating to daily care when engaging with both residents and relatives significantly improved because of the knowledge, skills and confidence they had gained. They were able to offer feedback, identify issues and appropriately respond to escalate needs to the nurse in charge where relevant. The same changes were noted where nurses no longer waited for seniors or managers to direct them or tell them what to do. Increases in confidence were evident from the secondary data showing that NH's complaints reduced over time. Its staffing levels did not increase but instead reduced as staff became more proficient and effective in the way they worked as a team, not wasting time waiting for referrals or escalation of simple matters that they could manage effectively because they now had the right knowledge and skills. NH, being a charity, also benefitted from increasing its occupancy, income and funding as a result of the reputation it built through improved standards of care and staff performance.

Managers highlighted that the other impact of staff being confident was the accountability, responsibility and team cohesion that occurred as a result. Skills for Care (2018) states that a lack of support for staff to develop skills and competencies in the care home industry results in turnover of staff as they feel undervalued, disempowered and stagnant in their career. The impact of education and learning at NH had the opposite effect; participants stated that they now felt a duty and obligation to stay on at NH as they could see a brighter future. This created a culture of loyalty to the vision of becoming a centre of excellence and being part of the future of NH.

The NH empowerment model focusses on developing each team member to identify themselves as a leader in everything they do at work. This includes supporting them to

understand the organisation's vision and identify how they can contribute to excellence through their acquired knowledge, skills and competencies. Stakeholder participants stated that they felt first that they had developed into leaders; for those who were already leaders, their leadership skills, approach and philosophy had completely transformed. They cited how they now understood the CHEC model and its application via the learning environment for every team member through CPD. They spoke of how this had changed their focus to identify talent and potential in staff, and they had begun to consider appropriate support to explore that talent through coaching, mentoring, supervision and challenging practice.

Stakeholders provided evidence of a leadership philosophy of empowering staff through education to make a difference. NH offered leadership education to care staff and managers alike, to emphasise that leadership was everyone's responsibility, to ensure that the right care is delivered in the right way. Feedback from stakeholders was that quality assurance improved as all staff members' performance and focus was on excellence through capabilities. This is a different approach from that used elsewhere in the industry where leadership support is considered only for staff in management roles. Stakeholders at NH related their own experience of being supported when they were care staff and how this had motivated them to develop into positions where a few became managers in the organisation over time.

Stakeholders' improved confidence and change in leadership philosophy—where they now considered that each team member had potential value in terms of the organisation's vision—created a culture of transparency and openness that facilitated staff in questioning, offering advice and suggesting alternative approaches when they noticed practice was not in line with the organisation's values. First, the leadership philosophy through empowerment facilitated the embedding of NH's values, which became the key drivers for care and not just procedures in tasks. Second, the increased confidence in this conducive culture allowed staff to feel empowered to raise issues and feel they would be listened to. The managers also gained confidence in the capabilities of staff and thus became able to listen to them and support them to make a difference in the areas they identified. The reason for this working well was that the culture was no longer one of 'them and us' between leaders, clinical teams and care staff—everyone valued the contributions, views and competencies of each team member as they could see those values demonstrated in practice.

Evidence from the stakeholder interviews suggested that staff became proactive in identifying and communicating changes and potential risks before they became imminent or led to major

incidents. This was evidenced not only through the stakeholder participant interviews, but also through the secondary data collected, which indicated a substantial improvement in KPIs in relation to incidents, health and safety matters and resident behaviour, which presented challenges. In view of the literature review in chapter 2 of this thesis, the regulator CQC and Sutcliffe (2016) highlighted that care homes underperform because of significant complaints and incidents—especially with residents with higher levels of dementia—the learning approach employed at NH seems to have had an impact on the performance of stakeholders, the organisation as a whole and the best outcomes for the residents at NH.

Finally, the design of the CHEC and the learning process as outlined above led to NH achieving its ultimate goal as defined in its mission statement: to empower dedicated staff so that they can deliver PCC in an evidence-based way. Stakeholders were clear that they felt empowered, hence their personal development into new roles, responsibilities and qualifications. Most profound was that the stakeholders interviewed represented all groups and levels of roles in the organisational structure yet all provided very similar feedback. The selection included staff from different departments, and not just carers. Thus the fact that those staff provided similar feedback—that they felt empowered to make a difference in whichever area they worked—is evidence of a transformational framework of learning that encompasses all the major functional departments that make up the business. The impact of staff feeling empowered was that they were able to remodel their approach and adapt to any changes they faced as a result of looking after a super-aged population which is residents over the age of 100 years, and those with advanced levels of dementia, such as those not cared for in any other care homes that do not specialise in that level of care dependency.

As established above, collaboration between staff, residents and relatives through RCC was evidence of a superior level of engagement where staff did not rely on traditional communication channels that involve external stakeholders communicating only via the managers of a home or other unit. The literature provides evidence that the latter leads to inefficiencies as managers end up focussing on daily tasks and mundane operational issues, and therefore miss the opportunity or scope to step up and perform at leadership level. This inefficiency is characterised by managers not having time for coaching, supervision and mentoring staff through a CPD programme because they have KPIs and reports that take up most of their working schedule. As established in this chapter, developing leadership requires a different philosophy and approach to CPD, which often means delegating operational

procedures to other staff upskilled to provide support in specific areas. When managers are engrossed in procedures, the outcome is more paperwork to meet compliancy standards and less focus on qualitative outcomes that require supervising practice, coaching, establishing values and supporting staff to feel empowered.

The literature review did not reveal an empowerment model, nor did it offer a definition of what this means in the care home industry as it is new and currently unique to NH. Evidence from the case study at NH and how it deigned its model suggested that this is a process where a learning environment transforms the confidence and performance of staff through teaching, research, knowledge, skills and competencies to foster a culture of CPD and excellence through leadership. This model encompasses all aspects explored in the current study about the meaning of learning and what the environment would look like. The stakeholder groups interviewed reported that this empowerment model was the basis for the CHEC.

5.7.2 Impact of Learning on NH

To establish the impact of learning and education at NH the first set of secondary data reviewed was CQC reports for NH following its 2016 and 2018 inspections. These were accessed from within the organisation but are also available online. Prior to the inspection in 2016, NH had only achieved an overall ‘good’ rating in all the KLOEs. The 2016 CQC report highlights that NH’s observations during the inspection provided evidenced that the standard for PCC was embedded and proficient in practice, which contributed to its ‘outstanding’ rating. PCC is a new model of care designed to place the resident at the centre of all assessments, care planning and delivery. It is considered one of the most effective models for ensuring that care homes are meeting the individual needs, preferences and goals of each resident, as opposed to providing care in an institutional, task-oriented or neglectful way. CQC inspection visits evaluate evidence and practice for the whole period between each visit. Thus, NH’s 2016 inspection results stemmed from the two years since the previous visit which is critical in terms of understanding what factors contributed to the improved care standards. NH’s five year strategy plan and governance records, specifically its KPI audits (see Appendix 2, Sections 1.1–1.13) indicate that by 2016 it had already developed measures for quality assurance indicators specific to PCC education, practice and evidence.

In 2016, most of the KPI outcomes were 71–85% achieved. The training records evidenced substantial monitoring and resources had been invested in PCC practice since 2015. Appendix

2 evidences that in 2016, NH's training, and supervision and appraisal signoff for competencies were almost 100% complaint. This achievement is evident in outcome measures in the 2018 CQC report, which highlights even more improvements. It confirms how NH was consistent in its PCC practice and how key stakeholders (residents and relatives) gave positive feedback that their needs were met and care individualised. Evidence from NH's five-year strategic plan, governance notes and training records indicates that NH had introduced PCC champions trained to support, evaluate and monitor PCC, while mentoring staff to improve performance and practice. The literature review highlighted that care homes that seem to provide better standards of care follow PCC principles, although this is not always done consistently across the industry. The secondary data collected also established that NH had managed to maintain that consistency in practice from 2015 until at least 2018.

5.8 Learning/Skills Policy at NH

An analysis of NH's learning objectives shows that PCC education mandatory in comparison with training expected by CQC and or offered by other care homes as outlined in chapter 2. Literature review also highlighted PCC was mandatory from induction and had competency outcomes to evidence its principles in practice. This expectation for staff to demonstrate evidence of PCC in practice was built into each staff member's signoff process stating they had successfully completed the course. PCC assessments and observations in practice were conducted by the PCC champions who ensured that each staff trained was performing a proficient level before deemed to have qualified.

This is a different approach from the teaching care home pilot introduced by Care England as well as industry practice, where there are no processes to check whether training in PCC is evident in practice. The literature review indicated that for knowledge to be translated into practice, there needs to be a standardised competency framework that evaluates whether staff are performing in line with learning outcomes. The researcher notes that there is no industry guidance or requirements for PCC to be mandatory for staff and for competencies to be signed off. This seems to be the difference that enabled NH to not only improve its PCC standards in practice after 2016, but to sustain these standards while improving care until its next inspection in 2018.

CQC's 2016 report goes on to outline that NH was proficient in EoLC for its residents in another standard under the category of 'responsiveness'. EoLC is considered one of the clinical

indicators that a nursing home has good systems and structures to deliver good care if they are able to demonstrate meeting care standards in that area. At the point of NH's inspection visit, according to its governance records reviewed in reference to admission trends, NH's average age of admission was around 87 years and its average length of stay was around five years. This was significant as it revealed that staff were dealing with complex care needs and frail residents, yet were able to improve the way they delivered that high standard in practice. Data that contributed to the outstanding rating in EoLC was the significantly lower rate of admissions and transfers to hospital for residents who were unwell.

According to NH's KPI audits from 2016-2020 (Table 4.3) indicates that hospital transfers and admissions of residents at EoLC was only 20–25%, significantly lower than previous years where the rate was 40% according to the governance trends analysis for before 2016. This is even more impressive given the national average of 45%, based on the NHS accident and emergency statistics for admissions from care homes for 2016. A contributing factor to these positive results as cited in the 2016 CQC report was that NH had developed systematic relationships and worked closely with local hospices, which meant it was able to access support for complex care. This is significant as most care homes do not have strong collaborations and relationships with their local services for clinical and medical support. The 2016 CQC report also highlighted that staff development in knowledge and skills to manage palliative care had contributed significantly to improved standards in that area. This was echoed in the feedback from the staff, relatives and other professionals working at NH as well as family members interviewed by the CQC inspectors during the 2016 visit.

The 2018 CQC report highlighted that EoLC standards had improved even more by the time of inspection. This information is corroborated by KPIs (Table 4.3, Sections 2.5 & 2.6), which showed that practice targets and outcomes under the GSF for palliative care (EoLC) were consistently achieved from 2016 to 2020. All residents had advanced care plans to confirm their preferred place of death, last wishes and treatment plans. This reduced the need for hospitalisation, especially when the preferred place of death was the care home. This is corroborated by data from NH's KPI outcomes for that period of time. NH's EoLC strategy states that to achieve this standard, it had to improve the competencies, knowledge and skills of its nurses. It also developed specialist nurses and introduced EoLC champions who supported practice and education for all staff. NH's audits for overall hospital callouts and referrals (admissions) in 2018 improved as evidenced as evidenced the in reduction from 25%

to 10% within their Governance reports underpinning the KPI dashboards in appendix 2. In addition, 90% of residents died in their preferred place of care (NH). This fact is crucial in determining the impact and link between learning and care standards, because CQC and training records show that in 2018, all staff went through EoLC education from recruitment to CPD. This education was conducted in house by NH champions and took place in the care home with real residents where staff could translate theory into practice.

This is a different approach to that employed in other care homes for their EoLC training, which is mostly classroom based (online) and provided by external educators. NH's rationale for this change in approach is explained in its education strategy: to ensure that education objectives and outcomes are tailored to the organisation, residents' complexities, and staff knowledge gaps and competencies. These are outcomes that NH considered could not be achieved if training was outsourced. Considering that at NH between 2016 and 2018, annual deaths within the home numbered 40–50 for residents with very high complex clinical and medical care needs under palliative care, this CQC outcome was remarkable as most homes would not be able to cope with such a high volume. NH was awarded Beacon status by the GSF, which is the highest award any care provider can achieve. The research notes that NH's approach to making EoLC education mandatory, developing its own educators and placing champions to work alongside staff to evaluate, assess and check competencies differs from what other organisations and the industry were doing.

Currently, training staff in EoLC and palliative care within the industry is not mandatory in the industry. Most care homes do not provide this training but rely on the support of hospices, which tend to deliver these sessions under the GSF framework. However, homes must opt in and pay for the training, which can often make it costly, especially when there is high staff turnover. NH's rationale for taking this different approach was that it considered EoLC as complex and thus requiring specific learning objectives and competencies for staff to perform better and meet complex care needs. It also believed that developing its own educators was paramount for ensuring consistency in delivering this education and monitoring practice while supporting staff to develop the necessary confidence to use their knowledge to change care outcomes.

This notion was supported by the literature review, which highlighted that to create an effective learning environment, it is crucial to establish clear learning objectives that meet the demands of staff practice, and ensure relevant resources are available consistently as competencies can

only begin to develop when staff feel confident and empowered to practice what they have learnt. Furthermore, literature review states that absence of the appropriate resources and support limits the ability of any training in which an organisation invests to influence outcomes in practice. NH's success can be attributed to its investing in champions, competencies and clear learning objectives.

The other standards of care that fall into the KLOE category of 'responsiveness' are complaints and concerns. NH evidenced a clear and transparent system of managing complaints from its residents and relatives in 2016. By that year's inspection, complaints had declined by 25% from the previous two years. Eighty % of all complaints were also resolved within NH's target time of 28 days. This was supported by further secondary evidence involving NH's KPIs (Table 4.3) between 2016 and 2018 in Sections 1.1–1.6, which highlight complaints decreased by about 25% and achieved above 90% resolution rate, compliments improved by 50%, and relatives and residents engagement improving from 51%. According to ONS (2018) reports on care home complaints and management processes, NH's performance in engagement and preventing complaints is far more proficient than the national average of 55% across the industry.

This research considers the above point profound for two reasons, first only 1% of care homes achieved an 'outstanding' rating in 2016, identifying NH as one of the few homes getting their care model and approach right. Secondly, being responsive to a changing industry and able to evidence this in practice, as highlighted in the CQC reports, signifies that leadership had managed to create a culture of improvement, learning and reflective practice. This is confirmed by the way NH managed complaints and concerns, achieving positive outcomes especially being the largest single-site care home in the UK with more residents and relatives from diverse backgrounds to meet expectations requires a complete positive and consistent demonstration of good care and an open culture to learning from mistakes. The literature review established that change and transformation in organisations that leads to outstanding performance begins with culture being 'set right'.

NH's outstanding outcomes provide significant evidence regarding the beginning of its journey to a 2018 overall 'outstanding' rating in the other three categories in Figure 4.1. Further, the CQC report identifies that NH's organisational culture involved proactively improving practice and engaging with stakeholders to prevent complaints. Where there were issues, there was a clear system to investigate and resolve them immediately and satisfactorily. Complaint records

viewed as part of this research also indicate that a new system of managing, recording and reporting complaints was implemented earlier in that year in line with NH's strategic objectives to listen more to its stakeholders. The new system included a new reporting structure and form, which was designed to promote learning and reflective discussion following a complaint. The intention was to identify opportunities for staff and managers to do things differently. This culture of reflective discussion is considered to encourage learning as evidenced by the literature review in Chapter 2. Training records at NH also indicate that complaints training was provided when the new system was introduced. This was evidence that managers and key team members practised using forms and as part of the training, their completed forms were marked, evaluated and feedback given on what to improve.

The design of the forms and training that linked with the complaints policy meant that staff were clear about how to manage situations. The literature review also identified that a learning environment is created when staff are empowered to have the right understanding, knowledge and skills to complete a task. Only then will they adopt the accountability and ownership attitude that is considered to improve their own performance. Evidence of how NH approached its complaints training by linking it to competencies and policies and empowering staff to reflect also meant that the culture of transparency, as observed by inspectors during the 2018 inspection, was supporting their findings. Governance records also indicate that complaints were evaluated at executive level and action plans from meetings indicated a high level of support and a culture of transparency. The literature review suggested that organisational culture contributes to the learning attitude of staff. If the executive team had a less supportive attitude and approach to complaints, the culture in NH could easily have become one of hiding and not reporting matters. Further, staff would not be willing to openly talk about mistakes, which limits opportunities to learn in practice.

The organisation's complaints policy and training reviewed during this research also indicated that NH's values were included in all its complaints systems to align expectations with practice across the organisation. The literature review also indicated that if a learning environment is supported by the right values demonstrated by the organisation this creates a conducive environment for staff to feel listened to and not afraid to speak out when things are not working well. In NH's case, this is linked to how it became outstanding in being responsive: this required each staff member to demonstrate the right attitude when dealing with 215 residents and each of their relatives.

After reviewing all the secondary data and how NH connected its building blocks, Figure 5.2 was constructed to encapsulate how each approach and component linked to bring about the desired change.

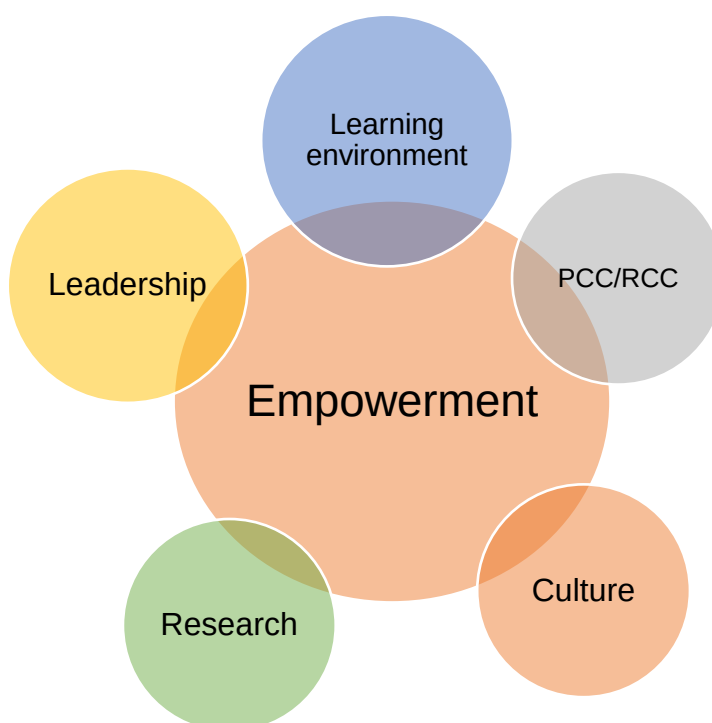


Figure 5.2: Empowerment model Source: NH CHEC strategy (2018)

The organisation's vision for education is to create empowerment of its staff to deliver its vision of excellence in care, and this was reflected in everything they did. NH replaced traditional training with a CPD approach to empower its staff through learning. This learning was blended and tailored to residents' needs, and staff learning styles and capabilities. The learning took place within the care environment and included case study, reflective practice simulation, tests and assessments to ensure that knowledge was translated into practice outcomes. To address the human factors that affect a learning environment and can prevent staff from practising what they have learnt, NH used PCC and RCC as the foundation of the experience of residents and staff in the care home. RCC focusses on understanding, building, valuing and promoting strong relationships between residents, staff and the care team, ensuring they work as one. Education and empowerment of each of these groups at NH improved how they collaborated, communicated and valued each other's contributions, which led to more outcome-based care for the individual receiving care. This provided a conducive, safe and relaxed environment where staff could learn and practice in a flexible way while doing their job.

Both RCC and PCC created a culture in the organisation that allowed transparency, accountability, responsibility and a safe conducive place for staff to want to learn and try new approaches. This was complemented by the research focus created to challenge critical thinking, innovation and evaluation of practice. For all these aspects to work together, NH developed its leaders to facilitate the transition process from the previous model of care to this new vision of excellence. The education strategy and some of the planning meetings evidenced how the organisation believed that leadership should be developed in each of its staff so that they could start exhibiting some of the characters and behaviours that are linked to that level of practice. This includes accountability and responsibility in practice. NH's leaderships focus was also to bring a sense of visionary thinking, planning and delivery of care. Its vision was that every staff member should be empowered to think, study, plan and act as a leader to bring the organisation 'one inch' closer to that vision.

5.9 Challenges in the Provision of Learning to the Health Sector

My observations in the 17 years of working in that general practice within the industry is providers tend to refresh these mandatory courses annually. However this is done as a 'box ticking' exercise to meet the expectations from CQC regarding evidence of continuous training. There are no competency assessments, reflective practice requirements or means to test whether staff have improved their knowledge or that it is transferred into practice. As the industry faces many financial cuts, training budgets are very limited, which results in no training hours being allocated to staff to complete training. This means that staff are pulled out of a shift to attend sessions as this is more cost effective than allocating separate days or paid time for them to attend off shift. The impact of this is staff is that they are not sufficiently relaxed but rather work under stress and cannot easily switch into learning mode, as the pressures of completing their daily tasks soon after training loom.

A contributing factor this stressful working environment is that the age range of admission in care homes 2020 is 85–92 years of age. This is substantially higher than 15 years previously when the range was 65–70 years. Thus people are coming into care much later in life when they have more complex care needs as a result of multiple comorbidities. This often results in crisis admissions whereby the person can no longer be supported at home and ends up needing emergency admission into a care home, often as a result of a serious incident such as a fall and fracture. Such situations present challenges to care homes as they require dealing with the pressure and difficulties of admitting someone who is very unwell, anxious and going through

a life-changing experience in a short period of time. Yet staff are expected to cope and deliver high standards of care with little background knowledge of the person's medical history or care needs.

It could be assumed that if this has been a re-occurring phenomenon, care homes should have developed mechanisms to cope with this challenge and demand. However, this is not the case because the Social Care funding system, unlike the National Health Service (NHS), is structured to support social care and not acute care. Income in the industry is driven by occupancy, which drives staffing ratios. The system is designed for planned admissions where deposits and first payments are taken before the person moves into the care home, allowing managers to source adequate staff in advance; it does not accommodate emergency admissions where there is an income contribution delay. Often, staff are not well equipped with the skills and experience to manage such complex admissions, which results in complaints and reports of serious incidents.

Thus, the care home workforce needs to be proficient in meeting a range of complex care needs for most residents from the moment of admission. In short stay of residents in a care home bed due to natural death at end of life also places pressure on care homes to try and ensure they quickly get new clients to maintain a full occupancy and maintain a sustainable financial position. This places managers in the position of making economic decisions and taking risks regarding emergency admissions as described earlier, notwithstanding the challenges this present to staff who may end up delivering inappropriate care.

Social Care funding will struggle to meet high demand as a result of the ageing population, and associated increased dementia and palliative care needs (Age UK 2020). The Department of Health and Social Care budget in the UK was £130 billion in 2017 and for 2019/2020 was only £139.7 billion (ONS 2020). There were general widespread concerns within the industry via media that this is not near enough to meet increases in care costs and demand. The impact of this is that local authorities, which fund 40% of care in the industry, have not been able to meet care fee increases in line with inflation, which has been steady at 2%. This results in funding cuts and zero percentage increases in contracts for placements. Smaller or single-provider care homes (60 beds or less) are most affected as they are not able to absorb the cuts because of low economies of scale compared with larger care homes. This forces operators to make difficult economic decisions when it comes to their biggest budget expenditure, which is staffing.

Meeting operational costs thus may involve cutting staffing ratios, not giving pay rises—which increases staff turnover—and reducing training budgets.

A steady consistent workforce is critical to maintaining and improving standards of care within a care home. Challenges faced by the care home industry include an average turnover rate of 25% of staff, which means there is no consistency in workforce standards. The impact of this is organisational loss of skills, knowledge and competencies when staff move between providers in a short period. The main reason for this level of turnover is staff looking for better opportunities to develop themselves and more stable and less stressful work environments (Age UK 2020). Through literature review I established that most care homes do not have an education framework for workforce development. They follow a national curriculum for staff training set by the Skills for Care organisation, which is contracted by the CQC to provide support and guidance on training to care providers. Such training is basic and not accredited, although mandatory for staff to attend. Staff tend to leave care homes in favour of NHS hospitals where they have better training opportunities because of a well-structured and well-funded system of workforce planning and development.

This is feared to contribute to poor standards in care homes, especially when operators resort to using agency staff who do not know the residents or the organisational policies and procedures. Providers are also then forced to recruit low-skilled staff with no experience in the industry. Without a proper workforce development plan, such staff struggle to meet the complex care needs of the frail ageing population in care homes. As a result, most care providers are struggling to meet the most basic of care needs for residential and nursing residents as recruitment costs divert any training funds available to develop these new staff.

Based on experience, I recognise that lack of resources to support training contributes to it being delivered in the least time possible. Common practice in the industry is to allocate one of the senior staff within the care home to be responsible for delivering training to the rest of the staff. There is no mechanism to ensure that this allocated person is developed to have the teaching skills to allow them to understand learning styles or how to structure a course and deliver it in an effective and engaging way. The literature review highlighted challenges in the industry with reference to the provision of learning and training. This included firstly the fact that most care homes do not have their own educators and assessors. This means that they are only investing in and focussing on mandatory training delivered by trained staff within the organisation. Other organisations use external consultants who come in whenever annual

mandatory training is due and provide a series of sessions to try and capture all staff. The literature review also highlighted that the main issue with this common practice is lack of consistency in the use of consultants. Selection is based on low cost to minimise training expenses. Inconsistent consultants add to the inconsistency of the information being provided, not to mention the disconnection between the consultants and organisation's values, focus and current challenges; consultants may not have full access to this information to tailor the outcomes and address any knowledge gaps.

Stakeholders interviewed reported that they experienced similar problems to one another prior to the introduction of the CHEC and the empowerment model at NH. Creating a learning environment included developing appropriate internal skills and competencies. However, the stakeholders interviewed did indicate that this was not easy at the beginning as the concept of education in this sector was new. A few staff who were initially trained took some time before they fully grasped the way in which they could support learning. There was no point of reference in literature that they could have been used to reflect on how NH could have been done successfully. Practice and reflective review workshops were used to bring the whole education team onto the same page over time.

The literature review highlighted a challenge in the industry whereby training, including the consultants who provide these services, is not standardised or regulated. It is up to each organisation to ensure that whoever they contract has the right skills and competencies to deliver training. While NH was moving away from this approach, it also faced the challenge of having to define the competencies required not only for each course it planned to deliver, but for each of the educators and assessors. Again there was no point of reference available for care homes, so NH had to learn through the process of developing courses and applying to City & Guilds to qualify as a centre in which formal qualifications were accredited. This process was critical as it was part of the learning environment objectives to offer professional development through formal qualifications for both educators and learners (staff). NH did however manage to meet all the requirements and evidence to demonstrate meeting the standards for City & Guilds and was finally registered as a learning centre. Achieving this made all other informal education needs easy to meet.

The other area in which stakeholder participants felt challenged was finding staff with the right background and education to be seconded further into the skilled role of assessors. NH's intention was to recruit from within but this meant that staff with no teaching background had

to go through a long process to qualify in adult education. However a few new staff had the right background so the focus became supporting them through induction so that they fully understood the model of care and philosophy at NH and were familiar with the values, principles and education system to meet the intended outcomes of their teaching. Thus, trying to standardise education within a new model being experienced for the first time not only by staff but by the new educators was a challenge at the start. Time and practice provided the confidence required by the Education Governance Board and the staff involved in the education strategy.

Another area that presented huge challenges was funding. As NH is a registered charity, its stakeholders and trustees were initially concerned that introducing a learning environment would divert the organisation from its main charitable focus. Once those stakeholders understood the strategy for the CHEC and were convinced of the positive impact it would have on the organisation, stakeholders such as donors still needed to be convinced to support the project. Consultation and meetings with key people were undertaken and funding was secured to facilitate the education and training hours and to create the environment where the learning would happen. The literature review highlighted the same challenge in the industry where most providers, especially small homes, struggle to finance basic care let alone investing in more training for staff. This becomes costly as staff must be replaced on units when they are undertaking training. However, NH managed this by considering the costs of staff turnover, sickness, absence, recruitment and poor reputation. It would appear that investing a fraction of that cost at the beginning to change the way the organisation feels and operates can have longer-term financial benefits that outweigh the initial investment.

Another challenge identified by the participants was the overstretching of the subject experts who became the educators and assessors while they were implementing the education and working in other main roles. It took some time for NH to build capacity in the resources it needed to deliver the education being offered as demand was high once staff began to actively engage with their CPD. It was reported that this was a stressful aspect for the educators and almost caused these subject experts to leave the organisation, which may have halted the whole project. Once more educators and assessors became qualified, there were enough to meet the demand. NH also included a succession planning programme to ensure it was always ahead of demand for the resources required to sustain learning and maintain the eLearning environment viewed in the CHEC. Introducing learning options at a slower rate might have avoided this

challenge. However, as the demand unexpectedly increased, another option might have been to allocate educators and assessors full-time posts to support learning early on and replacing their other clinical roles.

Poor IT skills was another huge challenge faced when the eLearning platform was first launched. Although a skills analysis of staff had been undertaken, most feedback received underestimated the level of competence staff required to engage with the new platform. Further, the eLearning was intended to be linked to the care management system so that care records, learning platform and other software applications such as the resident's alert system could be accessed via one system. During the trial phase, many issues were identified as most staff struggled to navigate the system. More time and education resources were put in place to assess and support staff. This proved to work eventually as staff became confident and independent. On reflection, it may have been beneficial to establish physical trial stations for staff to experience the system and then complete a self-assessment of their IT skills. This would have enabled a more accurate analysis of the IT skill level of staff and thus how much time and resources should be invested in the preparation phase before implementation.

The literature review also highlighted that IT skills are a general issue in the care industry as most care homes do use a computer for managing care records. Most staff who work as carers have limited IT skills and established in the case of NH when they completed their workforce skills matrix; therefore, when considering introduction of a learning environment with different resources such as eLearning, this is a challenge that needs to be well planned for as it can rapidly increase the cost of education should more IT training be required after implementing the new system.

5.10 Summary

Chapter 5 has reviewed the findings from the literature in comparison with the secondary and primary data. My analysis established that learning at NH is defined and evidenced through its CHEC model, which created a learning environment to meet all of the definitions identified in the literature review. This is despite adopted definitions of learning coming from other industries such as education and business, as learning environments do not exist in the health care industry as such. It has also been established here that learning and development is defined by CPD frameworks, for practice to change. I also explored how NH uses an empowerment model it developed to drive its CHEC implementation effectively. This chapter has highlighted

the importance of connectivity and access to learning within a learning environment. It exposed how NH achieved this by introducing eLearning platforms and other resources to allow easy access for staff, either while working or in their free time. More significantly, an area highlighted through analysis of the case study evidence is that NH's connectivity with universities to provide student placements and research participation produced profound results and impact on the staff, culture and learning environment.

An analysis of CPD framework for staff as defined in the literature and evidenced in the case study at NH confirmed purpose and use of supervision, appraisal, coaching and mentoring to develop staff into further education and senior roles. This framework was also shown to have improved succession planning, retention and workforce performance at NH. The extent of learning in the industry compared with at NH highlighted that training is still the focus for most homes with the limited scope of mandatory sessions as defined by the CQC regulator. The lack of skills, competencies and knowledge in the industry might be an inevitable result of that training practice that has not changed despite outcomes and performance. A lack of standardised or accredited requirements for training provided might also result in substandard training provided by less skilled trainers.

I analysed the impact of learning environment on stakeholders of NH when they changed from training to education, outcomes confirm a positive experiences in improved knowledge, skills, competencies, staff confidence, leadership, culture and total empowerment of the workforce at NH. To that effect, the evidence linked overall improvement in the way care is delivered and outcomes for residents. There have been many other improvements such as those outlined in the KPIs outcomes evidencing high achievements. My analysis of the process of implementing a learning environment revealed the main challenges faced by NH in delivering learning at the initial stages. Mainly the capacity to ensure adequate resources to support education and meet demand whilst developing staff's capabilities. Furthermore, operating in a compliance regulated industry where education is not measured the same way as training, which the regulators still expect to see during inspection visits.

This chapter has also analysed feedback from participants with reference to challenges and outlined how NH responded to these challenges and how they could have avoided them by changing the way they allocated educator hours to full time or creating self-assessment stations for IT competencies. In conclusion, Chapter 2 was very helpful in guiding the analysis in this chapter by providing available information regarding learning that is transferable to the health

care industry, since there is a lack of research in that field. The primary and secondary evidence provided also helped in the comparison with the literature review findings to explore differences between industry practice and the NH case study. This provides clarity around some of the opportunities that NH has implemented and how these worked better than current common practice in the health care industry.

Considering the social, economic and political challenges faced by the industry, it is becoming even more important for providers to consider cost-effective ways of delivering good care while utilising currently available workforce resources, as well as trying to meet the care standards defined by the CQC, which regulates the industry. This can only be achieved if the way in which training is organised, delivered and evaluated changes from current practice. This study sought to explore how NH managed to transform its training and the impact this had on some of the issues raised here.

Chapter 6: Conclusions

6.1 Chapter Introduction and Thesis Summary

This chapter comprehends all the data collected and analysed to draw conclusions on the extent of learning and its impact on improved the standards of care. To achieve this, I revisit my research questions to determine what evidence from preceding chapters states with reference to answering those areas of enquiry from a theoretical and practical perspective. Furthermore I look at the implications of policy on learning in order to ascertain whether the findings from this research can be replicated across the industry in order to achieve the same outcomes as in the case of NH. My intention is for this research to have profound contributions to future research within the industry. Hence this chapter identifies areas that require additional exploration based on some discoveries and areas where practice and research gaps were found whilst completing the analysis of data collected. Finally, this chapter discusses the methodology, theory practice and limitations of this research.

6.2 Reflecting on the Research Journey

At the start of this thesis I highlighted fundamental issues and challenges faced by the care home industry. Earlier chapters summarised substantial evidence for the need to develop staff with appropriate knowledge skills and competencies to improve care standards. Thus, the research questions were designed to evaluate the impact of introducing a learning environment in a care home. This focus acknowledges the learning environments introduced to other health care settings such as hospitals and hospices, and the lack of any such environments in care homes in the UK or Europe. Prior to undertaking this DBA program, I had explored existing models in Europe and travelled as far as Australia to examine what other care home organisations were doing in relation to learning environments.

Through my research and data collection, there was no evidence of a model where a learning environment was part of the organisation's strategy and model of care. I also contacted other providers in Sweden, the Netherlands and Sydney, Australia and even visited a few in a quest to understand how they developed their models. None had a model remotely similar to the one implemented in the case study of NH. Existing models in Europe and Australia both had links with university institutions that provided learning for their workforce, this was a commissioned

service rather than an internal model provided by the care homes. This investigation process led to my connection with NH and decision to start the DBA and use NH as a case study to introduce learning and create an environment conducive to supporting the learning structures, culture, systems and philosophy. Over the past 5 years I have been at working at NH, there has been significant benefits for the organisation but these had not been explored from a research perspective. Thus, this DBA study aimed to evaluate whether NH had improved its standards of care from 'good' to 'outstanding' as a result of introducing a learning environment; and if so, how.

To complete that evaluation, tailored research questions were selected and structured to explore some of the known and unknown gaps in the care home industry where research had not been conducted to specifically understand what constitutes learning, how this contributes to changes in staff performance and how this translates to changes in standards of care. The questions also sought to understand the relationship between NH's improved standards of care and introduction of its learning environment through an 'empowerment' model delivered via a CHEC framework. NH was selected as the case study because it is the largest single-site care home in the UK and has shown sustained improvements in care standards despite providing care to the super-aged population and residents with the most complex care needs in the industry. Further, as far as is known, NH is the only care home in Europe, Australia, Africa and Canada that has been able to create and implement this model and framework for a learning environment.

6.3 Revisiting the Research Questions

The aim of my research was to evaluate the extent of a learning environment and its impact on standards in care homes. My findings have concluded that a learning environment does have a positive impact and proven results on improved standards of care in the case study of NH. This next session uses my research questions to articulate and outline exactly what the conclusions are and recommendations relevant to the industry on issues raised through each question.

6.3.1 How is learning currently delivered at NH and how does this differ from the care sector?

Learning at NH is defined as continuous development of staff to achieve the appropriate knowledge, skills and competencies through formal and informal education and assessments

via multiple structures of learning resources. Learning is also defined by the objectives and outcomes linked to the vision of the organisation to become a centre of excellence, its mission to deliver evidence-based PCC practice and its CREDIT values. This thesis has provided evidenced for this being a unique approach relative to the rest of the sector in that most care homes only provide training defined by CQC standards for sector. This thesis has identified the core mandatory courses that most organisations focus on. There is no defined competency structure that is standardised so that eLearning objectives and outcomes can be measured in practice. As training is either outsourced or provided via ‘off the shelf’ training material (DVDs or slides), it is not always tailored to the challenges, needs and policies, procedures and values of the organisation. This also suggests that training is considered a standalone process undertaken annually to meet compliance needs. Therefore, no investment and connection between learning and standards has been established.

NH’s focus on CPD with skills and competencies as measurable outcomes differs from the rest of the sector in that it places an emphasis on long-term improvement plans for each staff member. This involves assessing individual capabilities and potential, and creating pathways that lead to sustainable career development opportunities that are linked to future opportunities in the organisation, which in turn produces commitment to learning. This further enhances how each staff member contributes to the organisation’s five-year strategic plan and succession planning. Learning is integrated into the workforce development strategy so that recruitment, induction, probationary reviews, supervisions, appraisals and reflective meetings are all opportunities to coach, guide and empower individual staff to meet specific SMART objectives, such as the KPIs of the organisation.

The principle design of these sessions is that each staff member interacts with them every two months. This is audited for consistency and quality assurance to ensure that each staff member is receiving the right support from their supervisor to maximise their potential. The rest of the sector does not provide such a high level of CPD with permanent outcomes as such; while most care homes undertake supervision, there is a general focus on compliance with CQC standards to ensure the right amount of supervision is completed annually. Again, this is viewed as a separate administration process with no quality assurance for learning objectives and outcomes, unlike in the case of NH.

NH has been able to achieve career development linked to learning via the capacity to offer learning with informal and formal qualifications accredited by City & Guilds since it became

an accredited centre and is meeting educational standards through qualified educators and assessors. Most care providers in the sector do not offer formal qualifications as this is not a requirement of regulators; this is optional for homes that want and can afford to invest in their staff. Care homes offering accredited qualifications accomplish this via external accreditors and institutions such as colleges and universities. NH has demonstrated the value of delivering these qualifications in house as there is more emphasis on practice outcomes relevant to the care home industry. Classroom training in a college or university—even when face-to-face support is available in the care home—does not deliver the same outcomes as having the course completed within the working environment of the staff with educators who also work for the organisation and have specific experience in the field as subject experts.

This is another way in which NH's education delivery is unique in that all learning at NH is delivered by qualified educators with competencies in adult education, specifically developed from within the organisation so that they have the right background and understand the philosophy of the organisation and its values. These educators are developed to have the right skills and approach to deliver education through coaching, mentorship, face-to-face learning and reflective discussions to capture as many learning styles as possible. The care home industry's education system is very different in its approach as it focusses on mandatory classroom training, most of which is delivered by internal staff with training certificates but no educational qualifications in teaching. Most providers also use external consultants to deliver training as and when needed.

NH's education team is supported and overseen by an education and development manager and a subcommittee for governance systems that monitors and evaluates education outcomes against the KPIs set by the organisation. Audits and trends analyses are completed to ensure that learning outcomes are evidenced in competencies and skills and are having the expected impact on standards of care for the home.

It was established through this research that the education industry has a well-developed learning framework and defined learning environment. Although there are versions of a learning environment in hospitals and hospices, these are not well defined within a framework applicable to care homes as they focus only on clinical practice and the section of the workforce that delivers medical and clinical care; that is, doctors and nurses, who are considered responsible for the outcomes for patients. This approach neglects the largest and most influential roles played by care staff and other auxiliary staff such as housekeeping and

hospitality (kitchen) staff who spend the most time with residents and see them on a daily basis and thus are potentially key to identifying trends in behaviour, wellbeing and symptoms (nutrition, hydration, confusion, pain) if empowered to have the right knowledge, skills and competencies.

6.3.2 What kind of transformation occurred as a result of the learning delivered at NH and how relevant was it to the improvement of standards of care?

Primary and secondary data reviewed through this thesis provided evidence for transformation in the following areas:

1. **Knowledge.** Staff now have a better understanding of elderly care needs with specialist areas such as dementia, EoLC, PCC, RCC, frailty and many other comorbidities that they have to support in practice. This knowledge has been measured through tests and assessments conducted as part of the learning outcomes. Secondary data from educational KPIs and CQC inspection audits evidenced not only compliance in standards but also that staff interviewed during inspections had good knowledge. Stakeholder participant interviews confirmed this: participants stated that staff—even those who were new to the organisation—demonstrated better knowledge in practice.
2. **Skills and competencies.** Following on from the knowledge demonstrated, within the same subjects and specialist areas, staff now demonstrate the practical ability to master and deliver care interventions in a proficient way. This was evidenced in this research through the positive changes in NH's complaints, pressure ulcer incidents, safeguarding reports, hospital admissions, hospital transfers and deaths and other associated outcomes as explored throughout this thesis. These outcomes are supported through the CPD process introduced through the CHEC and empowerment model.
3. **Workforce management.** Introduction of a learning environment led to a significant reduction in staff turnover, sickness and absence, and improvement in recruitment of the right people attracted to working in an outstanding care home. The turnover and absence prior to the introduction of a learning environment caused problems with staff shortages on shifts, resulting in excessive agency usage, was expensive, unsustainable and created inconsistencies in delivery of care. NH no longer has those issues as it has a better, efficient and more stable workforce.
4. **Learning and development.** Prior to the learning environment, NH reported struggling with staff completing its mandatory training, as indicated in KPI audits prior to 2016,

in contrast with reports for following years after the learning environed had been introduced. There has been a significant renewal in interest in learning and self-development evidenced through over 85% KPI outcomes in modules completed by staff. More staff have also completed formal qualifications with each new staff member joining since 2018 having completed their care certificate as a foundation. This has empowered and motivated staff to engage in their own CPD, which is critical for developing a proficient workforce. Evidence from the stakeholder interviews also shows that staff are progressing from carers to senior posts as they develop knowledge, skills and competencies. Other participants highlighted how they had completed assistant practitioner, nursing and leadership diplomas through NH.

5. **Leadership.** The leadership framework of using coaching, mentorship, reflective sessions, supervision and appraisal with a focus on CPD has changed the experience for staff and how they are managed. Leadership education being part of the learning environment at NH has changed the culture and focus on leadership style to a transformational approach where staff in strategic roles are supported to develop the capabilities to make a difference, as leaders should. The success of the learning environment at NH including the governance, structures and systems introduced is underpinned by good leadership. This thesis explored evidence from interviews with managers, directors, nurses, team leaders and senior care staff that indicates that everyone is supported to understand and develop a leadership philosophy in their individual roles.

NH is now in a place where any staff member is empowered to influence change regardless of their role. This is due to a culture in which everyone is empowered through education and culture to understand the vision and how they contribute to it. Since 2018, a number of managers and department heads have won leadership awards at NH. Further, NH's award of placement provider of the year in 2018 is evidence of how its leadership has been transformed. The CQC outcomes for 2018 also include an outstanding leadership award to NH for the implementation, sustainability and innovation in care.

6. **Culture.** This transformed from a nursing and compliance model where care is driven by the standards expected by CQC and clinical outcomes to a more PCC approach underpinned by a relationship-centred model. This began with NH reviewing its values and vision in 2017 to signify a change to the way it wanted to express its beliefs and focus for care. CREDIT values were created and introduced into all NH's education,

policy, procedure and quality assurance frameworks. It now considers values integral to being outstanding and the key driver for care, not just performance.

This also means that a number of the focus areas for the organisation have changed from training to education of staff; a change in uniform policy to enable a more homely environment; and improved relationships between staff and residents. Medication policies have also changed from the use of institutional trolleys and medication rounds to individual cabinets in each room, which also means that more staff have been developed with medication competencies to support administration in a more individualised way that demonstrates PCC as opposed to the institutional approach in the sector involving 'drug rounds' conducted by nurses, usually within social or communal areas.

These changes in care practices at NH are a result of the learning environment allowing research into best practice and how this can be adopted and tailored to their care demands. They also changed its philosophy in environmental design to accept and adopt evidence-based practices from research around the most conducive spaces for people living with dementia, frailty and palliative care needs. This saw a review of its households to change lighting levels, reduce noise stimulation, improve wayfinding, improve colour contrast and increase outdoor access for all residents regardless of dependency and mobility. Its designs for future care spaces include the absence of institutional features such as nursing stations, shared communal activities and facilities, with a more cluster-focussed approach to create small homely living environments. This is important as the physical environment is critical to a successful learning environment where staff can implement best practice effectively. Further, the change in leadership style and thinking has allowed a more PCC approach to managing care rather than a compliance approach where all activities are based on process.

The development of the workforce to ensure the right skills, understanding and proficient competencies has allowed some of these concepts to be implemented safely. The learning environment has transformed NH's culture towards learning to introduce the CHEC and invest in resources that are not available in other care homes, such as qualified educators and assessors; and learning platforms with integrated care management systems to improve efficiencies for staff to access learning and care plans immediately while in practice. Staff are also empowered to challenge and question

practice, as was evident in the interviews with participant groups. This is not a common culture in the industry as highlighted in the literature review based on the research and findings by Francis (2012). Furthermore, he highlights disconnect between managers and care staff, as well as nurses and care staff, which creates a negative culture and thus reporting and training issues. In some circumstances, there is complacency where no one takes action.

7. **Standards of care.** Secondary data were collected and analysed for trends in CQC outcomes, which showed that NH's standards had improved from 'good' to 'outstanding' in 2018. Its KPIs also improved significantly as it demonstrated better outcomes in all its critical areas. Stakeholder interviews showed that the improved standards of care were a result of the learning environment, which had empowered the workforce to be proficient in practice.

6.3.3 What are the common challenges and constraints NH experienced and is likely to experience in the future?

Chapter 4 detailed some of the challenges faced by the organisation stemming from interviews with stakeholder groups. Most of these were operational and a result of mistakes and approaches of NH throughout the implementation process. After analysing those points, in view of how other organisations might adopt a learning environment like that at NH, this section summarises strategic challenges that are also relevant to other organisations and how they might negotiate them:

1. **Funding.** This was initially an issue as NH was building its capabilities to develop enough educators and assessors. As a charity, it managed to secure funding for certain roles and donations to cover the cost of courses and replacement hours. The initial investment was worth the cost savings it achieved once it had all the right resources and the CHEC implemented. Other organisations could similarly link with providers to share existing resources as this will simplify the process of implementing their own learning environment. NH decided to go for the highest accreditation process with City & Guilds, which meant that staff had to have certain qualifications. They could have opted for other accreditation processes like Edexcel with different requirements and fewer demands. NH also decided to introduce City & Guilds Care Certificate Level 2 to all new recruits. This required many education hours. NH did not have to take that

approach; it could have assessed staff who were new to the industry and required a stronger educational grounding from those who already had a National Vocational Qualification (NVQ).

The latter could have been supported in due course to spread the demand, or seconded to Care Certificate Level 3 when they were ready, instead of completing Level 2 and then progressing to Level 3. NH took this approach as it wanted to standardise learning for everyone coming into the organisation. Any NVQ completed in other organisations was not accredited and was provided by different educators; mostly by colleges. Further, NH wanted to improve the standardisation of education for all its workforce to develop excellence as part of its vision. Should other care homes wish to take the same approach, they might focus on staff who are new to the industry and build capacity slowly because the old NVQ would give those who completed it a beginning level of knowledge.

2. **Availability of evidence base.** A learning environment as defined in NH is a new concept. There was no reference for NH to learn from and compare with to determine what could work better. This resulted in it having to spend substantial time and resources in researching, trialling and remodelling various concepts it wanted to implement. The advantage is that NH staff learnt first-hand what worked better in reference to the institution. On the other hand, the leaders who were involved in the process had to build this model as a secondary task to their main job, which was to run the largest single-site care home in the UK, without diverting attention that might result in the organisation failing to meet its primary care objectives. As more resources became available through the research networks developed in NH in the form of around 10 PhD students, exploration of the many important questions was easily managed with the network helping to contribute learning from parallel models and ideas that could be applied to NH. Other care homes wishing to implement a similar model will not have to go through the same lengthy process as NH is willing to share its learning and model principles.
3. **Stakeholder participation.** When NH was developing its learning environment, it initially contacted a number of universities seeking partnerships with them for support to co-design learning and develop the CHEC model. The initial plan was to engage a PhD student from a university to implement a learning environment as their research project. The challenge NH faced was the difference in approach and focus between

academic expectations and what was achievable within a care environment where learners were not typically students but rather care staff who may not have the same background and focus as students who had decided to study in a university faculty.

This led to the introduction of the DBA student option with the director of care services, who had experience in the care home sector, designing the education and NH obtaining its own accreditation through City & Guilds so that it would be sufficiently independent to structure its education to meet the standards, challenges and expectations of the care home. In the event that other care homes wish to implement the same accredited learning environment, NH can partner with them under its accreditation and they can become satellite sites where courses accredited by NH are delivered to the same standards, without the organisation having to invest in working with a university where the costs and expectations may be a challenge to match.

4. **Managing demand.** NH employs over 350 staff at one site. Once these staff were engaged in the learning process, there was a huge demand from staff wanting to complete education courses and competency assessments. NH had underestimated the demand at the implementation stages. This created pressure for those delivering the education to meet demand and standards of education without compromising the main aspect of the business, which is to deliver care. This was addressed by accelerating recruitment or development of educators and assessors over time. The introduction of a succession planning process for each role will ensure that if there is a spike in demand due to recruitment or requests from other care homes wanting to access education through NH, there are sufficient resources to support this.
5. **Identifying the most relevant learning resources.** Extensive research was conducted to find identify right learning material, tailored to match the learning philosophy at NH, which includes PCC, RCC and its values and focus on empowerment and not compliance or clinical care. A number of companies were approached to present their learning libraries for an eLearning platform. NH was seeking an eLearning platform that would allow multiple approaches to education including short videos, audio clips, learning courses, library, case study building capabilities, PowerPoints for presentations, and tests and assessments for knowledge and understanding. Most providers only partially satisfy these requirements.

Further, NH wanted a system that would give it the access and flexibility to edit and tailor material to meet preferred outcomes. Most providers offer only standard learning platforms that must be edited by the provider. After consultation with Altura and visiting their studios where videos and learning material was produced, it was felt their system was more compatible with the NH vision. However, NH still produces certain training that is not included in the learning library and the platform allows for new courses to be produced within the library with editing support for both courses and video content.

6.3.4 What are the lessons learnt from the past decade of investment, activities, success and failures related to the home care industry in the UK and what recommendations can be made?

After analysing all the data collected and the information relating to how NH implemented its education learning environment through the CHEC framework and empowerment model, there are a number of lessons the industry can learn. The following are the major impactful issues:

1. **Standardising education through accreditation-** in the past decade, the government has invested in ensuring NVQ training was available and accessible across the industry as part of its workforce development plans. The NVQ system was created to standardise learning across the workforce, starting with Level 2–5, which was leadership. This learning was supported by Skills for Care, which was funded by the government to roll out this education. It was mainly offered through colleges but eventually some organisations such as St Christopher hospices developed capabilities to support care homes through their qualified assessors, who visited homes and provided practical assessments for a fee. Other private organisations developed a business providing qualified assessors to complete the NVQ within the care home if they had enough learners, which also involved a fee. This was a successful approach and did help to kick-start the framework for training in the industry. Many staff benefitted from having structured learning objectives and a qualification that was transferable within the industry. NVQs were withdrawn in 2015 and replaced by the new QCF.

Although the NVQ was a practical and work-based qualification, it was not regulated, which exposed the system to misuse and misapplication, especially when commercial private organisations began offering this qualification. It meant the standard of training

no longer was focussed on quality but on quantity as fees applied to the number of learners that had completed the training. The training could be provided by anyone trained to deliver it, not just in the adult social care sector but across all industries. This meant that some of the educators who delivered these sessions did not have the background and experience required to ensure the appropriate skills were being taught. The NVQ was also not regulated, which meant there was no way to enforce standards and outcomes. The QCF is more regulated, especially in the adult social care sector, and it is linked to the SOFI, which is used by CQC to inspect care homes.

The CQC standards around PCC and other mandatory requirements are part of the SOFI and inspectors observe staff in practice to check if they are demonstrating areas that are part of the learning objectives of the QCF. The drawback with the QCF is that, just like the NVQ, it can be delivered by colleges and other private institutions with the right authorisation and registration. However, it does not have to be accredited by a standards board such as City & Guilds. It can be accredited by multiple boards, which means that standards are monitored in very different ways depending on the region or board that provides the accreditation. This is what NH experienced when it was looking to become a learning centre and had to choose an accrediting body. It chose City & Guilds as this provided a better standard and required a robust approach in the delivery, quality assurance and monitoring of QCF courses. Other boards that were approached seemed to have a very relaxed approach regarding to whom these qualifications could be accredited in practice. This meant that other care providers looking to achieve the same qualifications and seeking a cheaper option could use an accrediting body that was cost effective.

From the lessons learnt in relation to standardising education through accreditation, my first recommendation to the industry is that the government re-evaluates how the QCF is delivered and quality assured so that a single accrediting body is identified and a single accreditation framework is followed to minimise variation across the industry.

The second recommendation takes into account that most care providers may not be able to start from where NH started, by developing the resources required to provide the right skills, competencies and qualifications for educators and assessors. Skills for Care, which is responsible for supporting and overseeing the industry's education

system, should create a register of educators and assessors, to ensure standardised and accredited education, competencies, skills and qualifications for everyone who delivers education in the industry.

Lessons can be learnt from a similar process used by the Nursing and Midwifery Council (NMC) whereby all nurses must be qualified and registered by the same body before they can obtain a Personal Identification Number to practice in the UK. Each year, nurses also have to ensure they keep a record of professional development and evidence of how they are meeting the NMC standards.

This ensures that practice is uniform across the UK. In terms of funding to support this change, Skills for Care can also adopt the same approach used by the NMC for its nursing registration. Each nurse pays an annual fee of 120 pounds, which is used to pay for the administration and revalidation process. The government is already investing in making Skills for Care the main provider of basic guidance and educational support to the industry. That funding could be reviewed and re-allocated to the new approach to accredit and standardise education for educators. This NH case study proves that using qualified and skilled educators and assessors who all work to the same standards and outcomes make a huge difference in CPD of staff. A third recommendation is that at the national level, Skills for Care could work alongside with providers such as City & Guilds to ensure that they share learning objectives and outcomes for qualified educators, assessors and learners in the industry.

At the care home level, any provider considering moving from a training to an education model such as that used at NH should consider investing in adult learning with accredited outcomes such as through the City & Guilds framework. The case study at NH highlights that for transformation to take place, CPD is paramount and provides an incentive for staff to engage with education that makes a difference in practice. They need an option of formal education that can further their personal development in a meaningful way. Interviews with stakeholders at NH indicated that staff need to feel they are benefitting from their efforts in learning and developing skills that benefit the organisation.

While this structure for educators and assessors is being established, care homes may consider partnering with organisations such as NH that are well established with educators and assessors as resources. They can benefit from either outsourcing such support or sending their staff to be trained and developed so they can become qualified and experienced to then implement a learning environment within their care home. While this may attract an initial cost, the case study at NH demonstrates that the benefits over time outweigh the initial investment. Within NH's vision to become a centre of excellence in the industry, it already has the ambition to be a provider of that education support and share with other care homes what it has learnt through the process of creating a learning environment.

2. **Transformation-** the industry is strongly focussed on a compliance approach to training and education. This has been driven by the need to demonstrate CQC requirement to pass inspections, rather than focussing on growing workforce knowledge, skills and competencies, with CQC outcomes becoming a by-product of an efficient workforce, as demonstrated through the case study at NH. This research highlights how NH changed its vision, mission and focus to begin investing in the personal and professional development of its staff with positive outcomes as demonstrated in Chapter 4. This approach is easily replicable if leaders in the care home industry change the culture of doing the bare minimum to meet CQC-regulated activities and pass inspections. Such a change in culture will require education of care home managers to create transformational leaders as NH did with its own leaders. This will also require CQC to review its standards for training and consider increasing expectations beyond the current fundamental standards, which seem basic in that they define the mandatory sessions each care provider should offer and yet have not set standards for what outcomes in education should be measured.

From the lesson learnt in relation to transformational impact, my first recommendation is that all care home managers undergo thorough leadership skills analysis and coaching to change their culture and prepare them as transformational leaders who will help develop a learning environment. As a CHEC, NH might be a placement environment managers can visit for their leadership in practice experience to learn how to create transformational change in culture and a learning environment through education, coaching and mentorship, as demonstrated by the NH empowerment model.

A second recommendation at national level to support transformational leadership is for CQC as the industry regulator to change its focus on inspections from quantitative audits of how many people attended training, to use of the SOFI model to assess skills and competencies by observing and asking staff how they can demonstrate certain care approaches.

A final recommendation at national level is that Regulation 18 of the CQC fundamental standards of care should be reviewed to outline sets of skills and competencies that should form part of the learning outcomes for education in care homes. It is not sufficient to state that a provider should assess what it feels is adequate to provide for its staff, especially given that over the past decade this has not produced adequate results. The mandatory sessions should be reviewed to detail other competencies as highlighted in Chapters 1–4 of this thesis such as in dementia care, EoLC, PCC and skills in assessing changes in deteriorating residents, which results in unnecessary hospital admissions and clinical crisis issues that could be avoided. This is where the industry is currently failing to meet needs.

Such areas are not covered in the current mandatory training requirements set by CQC. NH provides the best demonstration that when these competencies are defined and all staff are supported to achieve learning outcomes, they are empowered with the knowledge, skills and competencies that result in outstanding care outcomes. This recommendation goes as far as to suggest that CQC should replace training with an education requirement for documented evidence of CPD for staff under Regulation 18. This will change the current focus on mandatory training as the bare minimum that providers have to evidence and create a focus on a learning journey. NH can be used as a case study example of how to achieve this and could consider publishing journals and literature to share the stages it went through and what changes occurred once it adopted a learning approach through the learning environment.

6.4 Implications for Policy

The implications for policy change are at both the national and care home level as the previous section highlighted changes that need to happen to simulate the transformation that occurred at NH. At the national level, the recommendations consider that CQC as the regulator is mainly responsible for the culture that has developed in the industry where care home providers, to survive, must demonstrate fundamental standards in quantitative stats for mandatory training

that CQC expects during inspections. These training standards are minimal and do not meet challenges the industry is facing in providing care to super-aged residents with substantial frailty, complex dementia and EoLC needs.

This thesis identifies a compliance culture resulting from the regulator's approach to inspecting training, and therefore recommends the changes outlined in Section 6.2.4. It further suggests a change in policy on standards and quality assurance requiring that inspectors take a qualitative approach to evaluating the education delivered in care homes. This policy change should also include a focus on education rather than training, with an emphasis on CPD for each staff member.

Inspections should be conducted in a more positive and supportive way to encourage providers to learn from case studies such as NH and signpost providers of evidence-based practice, as opposed to the current process and climate where providers are fearful of inspections and inspectors are considered too punitive and robotic in what they look for as evidence of compliance. Further policy change is required at Skills for Care as a national provider of education support. Section 6.2.4 outlines recommendations to improve and introduce a qualitative framework for educators and assessors. A policy is required to ensure this framework is applied across the industry to establish the purpose, benefits, implications and outcomes of a standardised education framework for educators and assessors.

A policy is also required to outline how care homes can access these resources to ensure a fair process of availability across the nation. Currently, there is a disparity in standards of care between the north and south of the UK. Some of the statistic presented in Chapter 1 indicate that the further north, the poorer the standards of care. While this thesis does not focus on why this is the case, it cannot be ignored that there is a disproportionately higher number of underperforming care homes in the north even though the population of providers there is less than the south. One potential explanation is that because of salary differences between the north and south, most skilled nurses are attracted to the south where there are better opportunities and resources (Care Market 2018). This phenomenon would need to be addressed through policy to ensure that education resources as defined in this research thesis are equally available to northern regions where a large proportion of inadequate care homes are.

In terms of recommendations at the care home level, the NH case study highlights how it reviewed its vision, mission and values to align with and reflect its change in culture and focus.

This process was critical in setting the foundations for the education climate and replacing the compliance model of care it had been applying. It was also established that by doing so, NH introduced an education framework to replace training and linked this to CPD and KPIs so that knowledge is translated to practice outcomes. This suggests that for care homes to achieve the same outcomes in standards through a learning environment, the following policy changes are required:

1. **Education policy.** This needs to outline the knowledge, skills and competence outcomes that the organisation needs to develop each staff member to meet its vision and mission; demonstrate its values in practice; and meet the complex care needs of current and future residents. The education policy should define how these outcomes will be taught, assessed and evaluated to ensure a CPD programme that responds to changes in practice requirements and the performance progress of each staff member. It is critical for the policy to also outline the frequency of this review and evaluation cycle. NH is able to achieve success via two-monthly engagements with each staff member so that the right support is identified and implemented to keep up with progress. Such a policy would need to include quality assurance for education to not only measure progress of each staff member but undertake a qualitative analysis of how the education is delivered and how staff are learning, with clear objectives and milestones for each staff group linked to the overall vision of the organisation. As established in Chapters 4 and 5, educators and assessors need to have appropriate qualifications and resources to deliver the education.

This policy should also define what resources they need in terms of a learning library, education space and, most importantly, protected time to deliver sessions and follow up on practice. The education policy should also define the CPD courses expected for each staff member access and be supported to complete as part of the organisation's mandatory process. This should be determined by a competency framework as outlined earlier that identifies the needs of the organisation. CPD should then start from recruitment and be linked to induction, probationary reviews, two-monthly supervisions and the appraisal process. A further aspect of an education policy that should be considered is how to ensure a learning environment and culture. To achieve this, as in the case of NH, student placements, research, reflective sessions and case study should be included as mandatory components of the education process.

2. **Governance and quality assurance.** Most care homes do not have a governance policy that clearly defines the approach adopted for quality assurance. A change in policy at care home level should begin with the introduction of a policy outlining the standards the care home wants to achieve and the process it will use to implement, measure and review these standards. Current industry practice is that care homes use the CQC fundamental standards as their framework for quality assurance. This research identifies the gaps this creates in a compliance model and how NH improved when it developed its own standards and KPIs that established appropriate expectations for each department and coordinated efforts for everyone to contribute directly to a qualitative focus instead of a quantitative approach resulting in a task-orientation culture. This policy should also outline the governance team and the skills and background they require to ensure a more robust approach to quality assurance and provision of sound recommendations through expert advice.

It is possible for small care homes to work together and create a governance structure shared across a cluster allowing them to share resources and expertise. NH's case study demonstrates the benefits of using subject experts to review trends analyses of performance outcomes from KPIs linked to a quality assurance and education framework and how this can improve the monitoring and performance of an organisation. A similar governance and quality assurance framework is required across the industry. Perhaps CQC as a regulator can create guidance for care home providers to establish such a framework. NH might be used as an example and could share a template for how this can be achieved effectively.

6.5 Contributions to Research (i.e. methodology, theory and practice)

This thesis explores an area of research that has not been fully researched previously, in an attempt to understand how care homes can improve standards of care through creating what currently does not exist in practice—a learning environment. The learning from other sectors such as the education industry and the case study at NH provide the most applicable framework to apply in a variety of settings across the country. A case study approach has been most beneficial as there is a general paucity of literature about learning environments, and other learning environments that meet the definition as created in the framework of NH's empowerment model. NH, as the first CHEC in Europe and other parts of the world, provides

a wealth of data, background and experience and an outlook that would not have been possible to collect and analyse through any other research method.

A qualitative approach was also demonstrated to be the best research option in conjunction with the case study as it allowed data collected through interviews to explore some of the most fundamental and nuanced concepts that have a huge impact on standards of care but have never actually been adopted as a new way of supporting change. Overall, the methodology selected proved effective for comparing primary and secondary data against industry practice. Gaps in research recommended for further exploration were discovered through the process. Several questions and gaps identified in this research emerged from either the primary data analysis or aspects that were discovered that could have potential benefit to the industry. These were not part of the aims or objectives of this research but should be explored through further research to understand their impact on learning environments and outcomes. The following questions and topics warrant additional research:

1. **What is the impact of eLearning as a platform and the main resource for courses to be provided in the care home sector workforce?** This question is paramount as the industry is undergoing a technological transformation and more providers are switching to eLearning education. It is presumed that eLearning provides flexibility for staff to access learning on the go and in their own time, which might increase the learning time. However, no appropriate research has been conducted to evaluate the impact on knowledge and how easy it is to introduce such a system in a care home that does not have a learning environment. In the case of NH, eLearning has been successful because it is underpinned by a framework that comprehensively supports different learning styles and has well-designed support for IT and CPD.
2. **What impact does student placement and research have on learning outcomes for staff in a care home?** The NH participants provided much positive feedback regarding the contributions of student placements on change in culture in the organisation. The improvements in staff attitude towards learning and teaching others furthered the cross-fertilisation of knowledge, research and best practice that occurred between the students and staff, which all resulted in a better experience for which NH was recognised as the best placement provider in 2018. These benefits, if replicated across the industry, might be a simple way to influence culture change more widely across the organisation at no cost, as student placements actually attract an incentive payment to the care home.

Furthermore researchers are also a free resource for the care home that can contribute to innovation and culture change.

3. **What is the impact of staff loyalty on an organisation that has created value to individual staff through CPD?** Most participants interviewed indicated that they would do anything for NH as they had been given a meaningful career through the learning environment. The level of commitment and loyalty they showed seemed to be a key driver of them not wanting to let down the organisation. It would be interesting to examine whether loyalty to an organisation created in the same way can change and improve the way staff perform and also result in better standards of care. This could benefit other organisations and provide recommendations for how loyalty can be created in staff at low cost as it seems to have lasting benefits that are immeasurable.
4. **Future research opportunities.** Further research may need to be conducted to evaluate how the CHEC framework and empowerment model created at NH would perform if implemented in a setting other than NH. The concept is still new and has not been trialled in a basic care setting that has not undergone such tremendous transformation over the years to result in efficient and superior performance. While the model is achievable and replicable, further research in other settings may offer insight into other areas that may need to be adapted to make the process quicker and less resource-intensive considering that other care homes may not have the financial means to achieve what NH has.

Ultimately, this research makes a huge contribution to the industry by offering a solution to the challenges faced by more than 73% of care homes, which is how to transform their services into outstanding performance. The research also offers practical solutions in regard to the steps, model and framework with detailed explanations of what worked and how to put it into practice. It also provides recommendations for policy formation at both the national and care home level so that learning from the NH case study can have a similar impact across the industry. The research also identifies potential research questions that could provide alternative ways to improve practice and performance of care homes if found to have the intended outcomes.

6.6 Limitations

There are a number of limitations to this research due to the fact that the framework of a learning environment does not currently exist in the care home industry. Further, there has been no research on this topic specifically linking learning in a learning environment to standards of care. The industry focusses on training, which is a different approach from a learning environment where teaching and education follow the principles of developing knowledge. Although my research endeavoured to explore broader learning examples from other industries, such as the education sector, it was challenging to conceptualise a learning environment as described in the context of a school, college or university where students are there full time to learn, versus a care home where learners are staff who are primarily there to work. However, using the NH case study bridged this gap as the principles and processes implemented by the organisation support some of the concepts adopted from learning environments in the education industry as a comparison.

The other limitation is that most of the participants and stakeholders interviewed were so overwhelmingly impressed by the outcomes and achievements of NH that it seems there is very little feedback regarding negative aspects of the learning environment and implementation process to inform other providers. I had to probe further to get participants to reflect on what could have been done better or challenges that could have been avoided. Therefore, notwithstanding the benefits in terms of improved standards as already established, one of the recommendations for future research is to evaluate whether the impact of a learning environment would be as positively impactful in a setting other than NH.

The main challenge faced by this research was the fact that there was no other research specific to learning or a learning environment in the field of care homes. This being a new concept, much of the information and data collected was interpreted based on current understanding of how it could apply in practice, as there was no way of directly comparing findings. Further research may be required to facilitate comparison of findings and recommendations from this research. This may give future studies a better indication of what works and the impact it has on the standards of care.

Fundamentally, the global COVID-19 pandemic has had huge implications for the application of the findings as NH's learning environment was introduced before infection control protocols and procedures which now apply in the UK. This may mean that some of the defined activities

currently performed by NH as part of a learning environment such as partnership with other organisations may not be practical post COVID-19. This could limit benefits of engaging the wider community to support education, learning and research may need to be reconsidered depending on dynamic government guidelines on access and restrictions to travel. The introduction of a vaccine may also help to renormalise the situation, in which case some activities that require physical visits to NH can be resumed. Alternatively, NH could provide virtual sessions as the industry is also adopting new ways of networking and managing meetings, training, education and indirect functional activities. Most of the learning can be provided and supported through Microsoft Teams or Zoom to support both internal and external learners, as an example.

6.7 Directions for Future Research

This research has highlighted a couple of areas I would love to consider for future research in view of the potential impact to the wider care home industry. My research findings indicated that staff improved in confidence when they were supported through a CPD process within the learning environment. It would be interesting to explore further whether confidence was a result of the education or working within a learning environment. This question is relevant because most stakeholder cited confidence as one of the change factors that led to the improved staff practice. Research could look at the impact of confidence on care standards in practice and whether confidence could be gained in any other way apart from CPD. Findings could inform ways to instil confidence in the care home workforce as part of a strategy to improve performance and whether this could lead directly to improved standards of care.

Another area of further research will be around the impact Covid-19 has on the care home industry and its workforce from a learning perspective in view of social distancing and restricted access into care homes. There is opportunity to evaluate the impact of a learning environment post the pandemic in consideration of staff's changes in as a result of the pressures they went through the crisis. Furthermore, a future question is whether or not a learning environment be achieved virtually.

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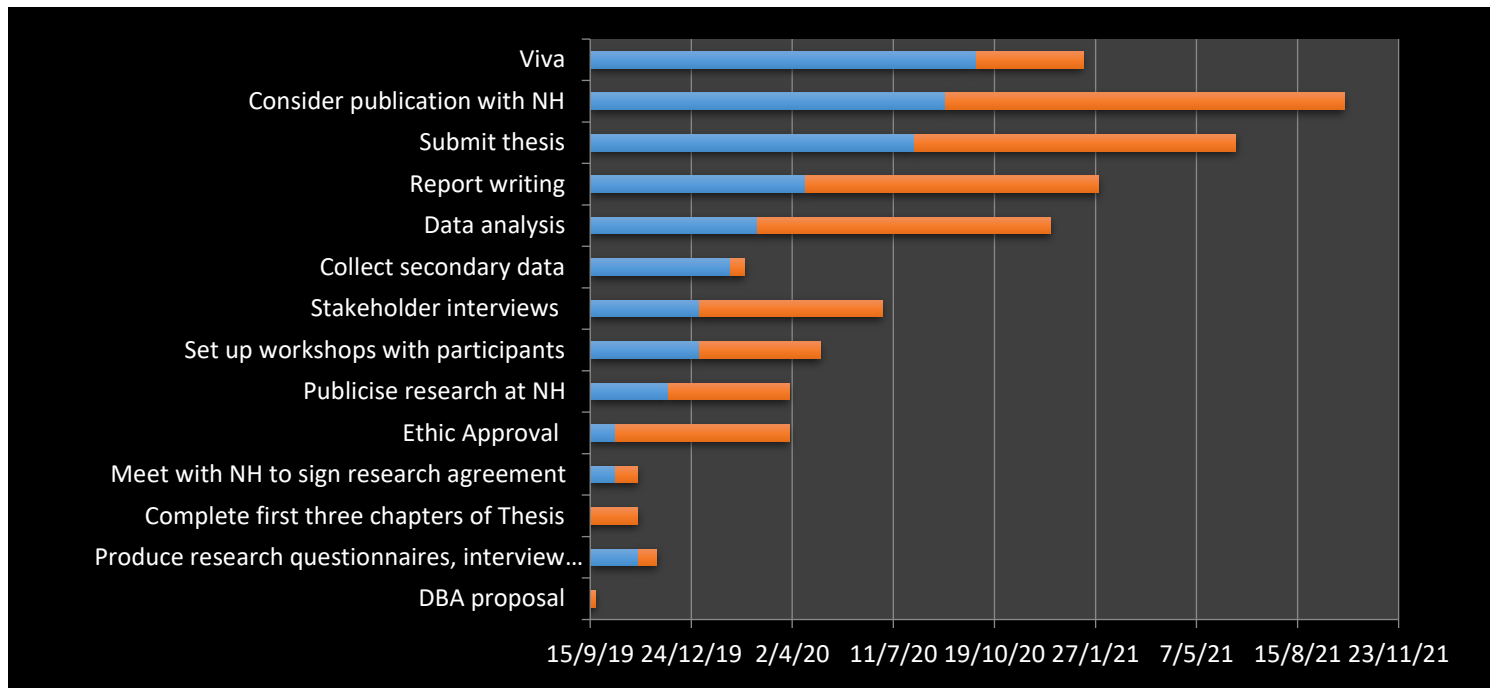
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Appendices

Appendix 1: Research timeline



Source: created by Author (2020)

Appendix 2: NH KPI summary (2016-2020)

[illegible]

Source: created by Author (2020)

Appendix 3: Stakeholder research questions

Research objective questions	Sub-question	Theme	Sub-theme
1. Definition of Learning environment Stakeholders -JMT -Care staff -Educators	-What is your understanding of learning? -What components are involved in learning at NH? -What is your understanding of a learning environment? -What is your experience of learning? -Where does this take place?	-Education -Teaching -Training	Definitions, staff understanding, awareness, involvement, Coaching, Mentoring, Practice rooms, Training facilities, skills, competencies, knowledge
2. Explore what characteristics of the conceptual framework and how this is adopted in practice? Stakeholders -JMT -SMT -Educators	-What educational policies/procedures are in place? -Who leads in education programme at NH? -Who delivers education at NH, what training and qualifications do they have? -What is the quality assurance and governance for education provided? -How and who evaluates practice after education? -How is practice and education linked?	-Workforce -Development -Strategy	-Course learning objectives/outcomes -Course delivery methods -Teaching resources -Learning evaluation tools -Supervision and appraisal process -Practice audits
3. What are common challenges and constraints faced by the care home? Stakeholders -JMT -SMT	-Has there been any challenges in creating a learning environment? -Has there been any constraints? -How easy was it to establish a learning environment? -What is not working so well? -How did staff react to this process?	-Costs -Resources	-Training budgets -Incentives for education? -Salary for educators? -Cost of education material?

-Educators 4. KPI's used applied to affect improvements and how the role of learning is perceived by the stakeholders? Stakeholders -JMT -SMT -Educators	-What has there been the negative aspects? -How did you deal with the challenges and constraints?		
	-What are NH's standards of care used to measure practice? -What are regulator's KPI's? -What is the process for reviewing KPI's? -How are KPI's linked to learning? -Which stakeholders are involved in the KPI's? -What information is shared with the stakeholders?	-Quality Improvement framework -Trends analysis -Reporting cycles	-Training stats -Complaints -Incidents -Disciplinary rates -Turnover rate -satisfactory surveys
5. What lessons are learnt in the past in relation to NH creating a learning environment? Stakeholders -JMT -SMT -Educators	-What were the outcomes from the initial evaluation of the project? -What could have been done better? -What mistakes were made in the process? -What would you avoid doing again?	-Failures -Outcomes from first pilot	-Staff surveys -Stakeholder feedback -Scrapped ideas -Lack of progress
6. Evaluate whether this model can be evidenced to changes in standards from Good to Outstanding? Stakeholders -JMT	-What learning objectives improved which KPI's? -What education influenced which changes in practice? -What staff competencies improved? -What staff skills improved in practice? -What staff knowledge improved in practice?	-Performance analysis	-Evaluating knowledge, skills, confidence, competencies and practice

-SMT -Educators -Care staff	-Did staff improve in confidence?		
7. Make recommendations on how this could be disseminated across the industry Stakeholders -JMT -SMT -Educators	-What aspects of the model are replicable? -What systems are common across the industry? -What resources can be shared or accessed by other providers? -What is the cost benefit analysis? -How practical is it for NH to support as a centre for education and train other educators? -Can NH be a centre of excellence were other providers can visit? -Can this model be published with easy step guide of how to “do it yourself”?	-Showcasing practice	-Workshops -Conferences -Journal -Interviews -Marketing

Appendix 4: NH research authorisation letter

nightingale hammerson

Nightingale House
105 Nightingale Lane
London SW12 8NB
020 8673 3495

Simon Pedzisi
University of Wales
Trinity Saint Davies

Friday 1st November 2019

Dear Sir/Madam

SID: L0042KNYKNY (1714632)

RE: Doctorate in Business Administration

I am writing to confirm permission/authorisation for you to carry out research in our organisation for the purposes of your DBA.

I understand that by giving this permission I am granting you the use and ownership of data collected.

I understand that you will produce findings as part of your thesis.

I understand that your findings will be shared with the University and other parties including publications.

I give permission for the organisation to be named in the publications.

I do wish to see the summary of findings before any publications and I believe all participants will be informed of this.

Yours Sincerely,



Helen Simmons

Chief Executive Officer
Nightingale Hammerson

Nightingale Hammerson Trustee Company Limited
Registered Office 105 Nightingale Lane London SW12 8NB
Registered Company No 07990530 Registered Charity 207316

Appendix 5: Participant Consent form (sample)



NAME OF PARTICIPANT:

Title of the project: **Evaluating the extent of a learning environment and its impact on standards in care homes: the case of Nightingale Hammerson (NH) nursing home in UK**

Main investigator and contact details: Simon Pedzisi email: L0042KNYKNY0218@student.lsc london.co.uk
Tel: 0777 5260561

Members of the research team:

1. I agree to take part in the above research and I have read the Participant Information Sheet (16/03/2020 version 1.1) for the study.
2. I understand what my rights are and all my questions have been answered to my satisfaction.
3. I understand that I am free to withdraw from the research at any time, without giving a reason.
4. I am free to ask any questions at any time before and during the study.
5. I understand what will happen to the data collected from me for the research.
6. I have been provided with a copy of this form and the Participant Information Sheet.
7. I understand that quotes from me will be used in the dissemination of the research.
8. I understand that the interview will be audio recorded.

Data Protection: I agree to the University¹ processing personal data which I have supplied. I agree to the processing of such data for any purposes connected with the Research Project as outlined to me*

Name of participant (print).....Signed.....Date.....

Name of person witnessing consent (print).....Signed..... Date.....

PARTICIPANTS MUST BE GIVEN A COPY OF THIS FORM TO KEEP
ADD DATE AND VERSION NUMBER OF CONSENT FORM.

I WISH TO WITHDRAW FROM THIS STUDY.

If you wish to withdraw from the research, please speak to the researcher or email them at (L0042KNYKNY0218@student.lsc london.co.uk) stating the title of the research.

You do not have to give a reason for why you would like to withdraw.

Please let the researcher know whether you are/are not happy for them to use any data from you collected to date in the write up and dissemination of the research.

¹ "The University" includes London School of Commerce and University of Wales Trinity and St Davies and its Associate Colleges.

Appendix 6: Group 1 stakeholder interview questionnaire



Name: For example Jordan Reverie

Position: Healthcare Assistant

Start Date: [Click here to enter a date.](#)

Q1. Introduction question

What is your understanding of a learning environment based on your time at Nightingale Hammerson (NH)?

Q2. Follow-up question

Could you describe what components are involved in learning at Nightingale Hammerson?

Q3. Probing question

Can you tell me about your experience of learning and how it takes place at Nightingale Hammerson?

Q4. Specifying question

In what way has a learning environment at Nightingale Hammerson influenced your practice?

Q5. Direct question

What aspects of learning environment do you feel have an impact on Nightingale Hammerson?

Q6. Indirect question

Do you think a learning environment has helped to improve the standards of care at Nightingale Hammerson?

Closing remarks: Thank the participant and check if there is anything else they wish to add.

Appendix 7: Group 2 stakeholder interview questionnaire



Name: For example Jordan Reverie

Position: Healthcare Assistant

Start Date: Click here to enter a date.

Q1. Introduction question

What educational policies/procedures are in place to support learning at Nightingale Hammerson (NH)?

Q2. Follow-up question

Could you tell me who leads in education programmes at NH?

Q3. Probing question

Can you tell me who delivers education at NH, what training and qualifications do they have?

Q4. Specifying question

What is the quality assurance and Governance of education provided at NH?

Q5. Direct question

How and who evaluates practice after education at NH?

Q6. Indirect question

How is practice and education linked at NH?

Closing remarks: Thank the participant and check if there is anything else they wish to add.

Appendix 8: Group 3 stakeholder interview questionnaire



Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David

nightingale hammerson

Name: For example Jordan Reverie

Position: Healthcare Assistant

Start Date: [Click here to enter a date.](#)

Q1. Introduction question

Has there been any challenges in creating a learning environment at NH?

Q2. Follow-up question

Has there been any constraints?

Q3. Probing question

How easy was it to establish a learning environment?

Q4. Specifying question

What is not working so well?

Q5. Direct question

How did staff react to this creation of learning environment?

Q6. Indirect question

What has there been the negative aspects?

Q7. Final question

How did you deal with the challenges and constraints?

Closing remarks: Thank the participant and check if there is anything else they wish to add.

Appendix 9: Group 4 stakeholder interview questionnaire



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Name: For example Jordan Reverie

Position: Healthcare Assistant

Start Date: [Click here to enter a date.](#)

Q1. Introduction question

What aspects of the learning environment model at NH are replicable?

Q2. Follow-up question

What systems within the learning environment are common across the industry?

Q3. Probing question

What resources at NH can be shared or accessed by other providers?

Q4. Specifying question

What is the cost benefit analysis of a learning environment?

Q5. Direct question

How practical is it for NH to support as a centre for education and train other educators?

Q6. Indirect question

Can NH be a centre of excellence were other providers can visit?

Q7. Final question

Can this model be published with easy step guide of how to DIY?

Closing remarks: Thank the participant and check if there is anything else they wish to add.

Appendix 10: Group 5 stakeholder interview questionnaire



Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David

nightingale hammerson

Name: For example Jordan Reverie

Position: Healthcare Assistant

Start Date: [Click here to enter a date.](#)

Q1. Introduction question

What are NH's standards of care used to measure practice?

Q2. Follow-up question

What are the regulator's KPI's (CQC)?

Q3. Probing question

What is the process for reviewing KPI's?

Q4. Specifying question

How are KPI's linked to learning at NH?

Q5. Direct question

Which stakeholders are involved in the KPI's at NH?

Q6. Indirect question

What information is shared with the stakeholders at NH?

Closing remarks: Thank the participant and check if there is anything else they wish to add.

Appendix 11: Group 6 stakeholder interview questionnaire



Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David

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Name: For example Jordan Reverie

Position: Healthcare Assistant

Start Date: [Click here to enter a date.](#)

Q1. Introduction question

What were the outcomes from the initial evaluation of the project?

Q2. Follow-up question

What could have been done better?

Q3. Probing question

What mistakes were made in the process?

Q4. Specifying question

What would you avoid doing again?

Closing remarks: Thank the participant and check if there is anything else they wish to add.

Appendix 12: Group 7 stakeholder interview questionnaire



Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David

nightingale hammerson

Name: For example Jordan Reverie

Position: Healthcare Assistant

Start Date: [Click here to enter a date.](#)

Q1. Introduction question

What learning objectives improved which KPI's at NH?

Q2. Follow-up question

What education influenced which changes in practice at NH?

Q3. Probing question

What staff competencies improved at NH?

Q4. Specifying question

What staff skills improved in practice at NH?

Q5. Direct question

What staff knowledge improved in practice at NH?

Q6. Indirect question

Did staff at NH improve in confidence?

Q7. Final question

Do you think the learning environment improved standards of care at NH?

Closing remarks: Thank the participant and check if there is anything else they wish to add.