NICE National Institute for
Health and Care Excellence

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Tailored resource

Tailored service improvement support

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Implementing the home care guideline (NG21): for home care providers and commissioners

Introduction

This resource will help you implement NICE's guideline on <u>home care: delivering personal care and practical support to older people living in their own homes</u>. It explores how challenges to implementing the guideline can be overcome, and links to key resources and case studies to help you do this. It is particularly relevant to providers of home care services and commissioners in local authorities and the NHS. The resource will help to support the workforce and to promote collaborative working. Each section of this resource will pull out implementation challenges and opportunities, with links to resources, examples and further reading.

Why should you put this guideline into practice?

<u>The Care Quality Commission</u> (CQC) inspects home care services and uses NICE guidelines as evidence in the inspection process. NICE quality standards <u>inform CQC ratings of 'good' and 'outstanding'</u> and links between the <u>CQC regulations</u> and the guideline are highlighted throughout this resource. You may assume that implementing new guidelines will be costly. In fact, placing resources where they will be most effective can provide best value. NICE has prepared a <u>costing statement</u> to help with this.

Person-centred working

The guideline has person-centred working (recommendations 1.1.1–1.1.6) at its heart. It states that care should meet the aspirations, goals and priorities of people using home care. The guideline is based on principles of choice, independence and control, and focuses on achieving outcomes rather than completing tasks. This may mean a culture change for some services. True person-centred working is a process, not a one-off: the opposite of a 'one size fits all' model of care. Services need to work together to listen to and act on what the person finds important. Seeking regular feedback about the quality and suitability of care and making changes where needed means the person continues to get the care they need.

> CQC Regulation 9 relates specifically to person-centred care.

Why is person-centred working a challenge in home care?

Traditionally, home care has been commissioned and delivered on a 'time and task' model. This prioritises procedure and amount of time spent on care over meeting the needs of individual people. Often, home care workers have difficult working conditions and the work can be highly pressured (Social Care Institute for Excellence: Dignity in care – dignity for home care workers). This may compromise communication with the person and, ultimately, outcomes. Cost pressures can lead to commissioning short visits, compounding the issue.

Person-centred working, by definition, has no set of rules. Establishing the aspirations, goals and priorities of each person calls for conversations and time. Although actions can be taken to achieve person-centred care there is no formula for each individual. For some people (for example, those with cognitive impairments or sensory loss) extra time may be needed for communication. For others, the additional time may be needed for help with eating or drinking.

> **Key resources**
>
> Person-centred care starts with commissioning. The Social Care Institute for Excellence's Commissioning home care for older people: what older people want includes 2 short films. For local authorities in particular, the Association of Directors of Adult Social Services has produced a route map to help organisations commission with best practice in mind, including substantial material on person-centred care.

How can these challenges be addressed?

Establishing person-centred working

The only way to find out what people want or need is to ask them. This sounds obvious, but it may not be easy. Many people who use home care have cognitive impairment, sensory loss, or other communication difficulties. People do want to be listened to, but may be worried about losing a service if they challenge their current support. Their home care workers may also feel they do not have the time to listen, or the influence to bring about change according to the person's wishes. Managers should make sure that frontline staff understand the importance of and feel able to listen to what people say about their care.

Case study

A home care worker explains what person-centred communication looks like on the frontline. "I support an 89-year-old lady who is a football fanatic. I bring her the paper and she goes straight to the back page. She can fully explain the offside rule better than anybody I know."

Why the offside rule is important to the 89-year-old I support: my life as a home care worker Social Care Institute for Excellence.

Time for person-centred working

Without sufficient time, it is unlikely that a person's needs will be met in the way that they prefer. The guideline states that home care visits should only be shorter than half an hour if: (recommendation 1.4.2)

- the home care worker is known to the person **and**

- the visit is part of a wider package of support **and**

- it allows enough time to complete specific, time-limited tasks or to check if someone is safe and well.

Shorter visits should also be agreed with the person. The buying of home care is a powerful tool for making sure that services provide a good quality service that meets person-centred needs. Commissioners should ensure that workers have time to do their job without being rushed or compromising the dignity or wellbeing of the person who uses services.

Continuity of care

Wherever possible, the person should be supported by the same home care workers (recommendation 1.1.4) so that they can get to know each other. When a person knows their home care workers they develop confidence in the service and feel safe. Home care workers who know the person are better able to understand their needs and preferences. The guideline states that a home care worker should be 'matched' to the person; this too will support a consistent and person-centred home care service.

Case study

The Raglan Project in Monmouthshire (featured by SCIE) is replacing task-based care with flexible care. This focuses on the social and emotional (as well as physical) needs of the person being supported. Before the care begins, staff members establish a relationship with the person receiving care. Staff are then given the freedom to decide for themselves how the relationship and care should work – and their decisions are supported rather than controlled by management.

Communication

Communication in home care has 2 main aspects:

- communication with the person using home care (and their carer, family, or friends)

- communication among professionals.

It refers to both written and non-written communication. As with person-centred care as a whole, effective communication is an ongoing process. As a person's needs or preferences change, so may their preferred forms of communication.

Key resource

National Voices and Think Local Act Personal (TLAP) have produced a series of 'I' statements in A narrative for person-centred coordinated care expressing what integration and coordination of care and support look like to people who use services. It considers the outcomes and experiences that are most important to them.

It can be confusing if many different professionals are involved in a person's care and support. Good communication is vital for keeping misunderstanding and distress to a minimum. Ideally communication will be face-to-face – but this is not always realistic. Effective communication methods, such as using clear and concise language and listening carefully, should always be used, no matter what the medium.

Case study

People with communication difficulties or sensory loss may feel an increased sense of social isolation if they are not supported to maintain contact with their family and friends. Social isolation has a negative impact on mental and physical wellbeing. The Debenham Project (featured by SCIE) offers local support to those living with dementia. Volunteers (with professional support) lead a comprehensive range of activities, supporting both the person with dementia and their carer.

Care diaries

Care diaries (recommendations 1.3.22–1.3.24) (sometimes known as 'care records') are detailed logs of all care and support provided. They highlight the person's needs, preferences and experiences. Care diaries enable practitioners to communicate effectively with the person, the carer, and with each other – especially if practitioners do not routinely speak in person. Every

practitioner (including home care workers) should ensure that the diary is filled in on each visit, including details of any incidents or changes. It should be comprehensive enough to keep people, their carers and all professionals fully informed. Everyone involved in the person's care should always read new entries in the diary, adding information in, with the named care coordinator (recommendation 1.3.6) having overall responsibility for it. There is no set format for a care diary, but everyone involved in the person's care should find the format easy to use.

> **Case study**
>
> Mary A is her own care coordinator. She stores her care diary on her tablet device (including letters from her consultants, scan results and medication charts). Mary also has an app that helps her to monitor her vital signs and activities each day. Her care staff fill in a report on each visit, noting her health and wellbeing, her nutrition and hydration, her skin condition, and medicines. Mary gives home care staff copies of reports, but it is her information to control as she wishes.

Late or missed visits

As well as major risks to the person's health and wellbeing, late or missed home care visits (recommendations 1.4.10–1.4.15) can cause distress to the person expecting a call at a certain time. It can also break people's trust in the home care service. People who live alone, or lack capacity, may be particularly affected by changes to a usual visit. Any unexpected changes to a service should only occur in exceptional circumstances. They should be communicated immediately and in a way that is clear, meaningful and accessible to the person. Alternative arrangements for late or missed visit should be set out clearly. This may include making arrangements for a family member, carer, or neighbour to visit (and giving home care workers contact details for this person).

> The United Kingdom Home Care Association (UKHCA) has analysed the findings of Not just a number: Review of home care services, an overview of CQC inspections of home care services, and made some recommendations for providers. These include the recommendation that providers should consider auditing the number of missed or late visits (and the reasons for these) occurring over a minimum period of 4 weeks. They should then review their practice to reduce them.

Telecare

Telecare (recommendations 1.4.16–1.4.20) uses technology to help people live independently at home. It may include personal alarm systems and sensors. In line with person-centred care

principles, it should meet the person's needs and wishes and should not replace face-to-face contact (unless the person consents to this).

Good communication is important in telecare. It includes:

- offering information about their telecare options

- recording in the home care plan how the telecare equipment helps meet the person's needs (and ensure the person understands this)

- regularly reviewing the use of telecare to ensure the person finds it useful and that it continues to meet their needs (which can change over time).

People, and their carers, should be helped to understand how the technology works and (if appropriate) should be trained to use it.

Roles, responsibilities, and multidisciplinary working

Figure 1 – the web of care
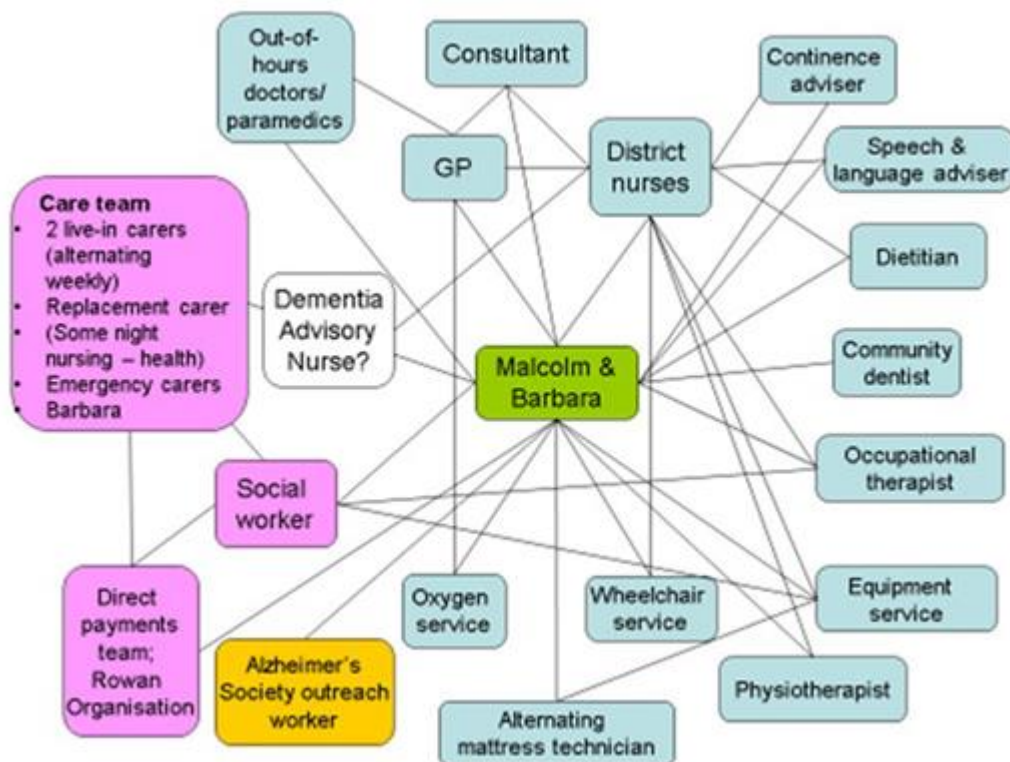
Working together to ensure care and support is coordinated is crucial. The different roles and responsibilities involved in care at home need to be carefully defined. People involved may include home care managers and workers, carers, healthcare practitioners (for example, district nurses and GPs); social workers; workers from voluntary or community organisations; and advocates.

This diagram is based on the experiences of a carer, Barbara Pointon, whose husband Malcolm had Alzheimer's disease. It shows how many people may be involved in one person's care.

> **Key resource**
>
> The guideline can encourage communication across boundaries. The NICE Collaborating Centre for Social Care (NCCSC) held a 'roundtable' event bringing together lots of different perspectives on home care to discuss the guideline. The report of this event also contains information on holding your own local roundtable event.

Named care coordinator

The named care coordinator should: (recommendations 1.3.6–1.3.9 and 1.3.14)

- lead home care planning and coordinate care

- ensure everyone involved in delivering care and support knows what they should be providing and when

- ensure everyone involved in delivering care and support is communicating regularly.

The care coordinator should also be responsible for ensuring the person's care diary is kept up-to-date and that it remains fit for purpose. This person is someone already involved in the person's care (not an 'extra' person). It could be any of the practitioners, a carer, a family member, or the person themselves: often, there will already be an unofficial care coordinator. The person who accepts the care coordinator role should do so willingly, and everyone involved in the care should know, and respect, the care coordinator's responsibilities.

Working together

The guideline explicitly states that health and social care workers should liaise regularly to deliver person-centred care (recommendation 1.5.3). This is in line with the Care Act (2014) placing a duty on local authorities to promote integration of care with health services. Working together can be cost effective or even cost saving (see the costing statement) – because seamless care at home reduces overlap and duplication. A series of quick guides from NHS England and partners can be used to implement solutions to commonly experienced issues in health and social care integration.

Local leadership across the health and social care sector is the foundation of coordinated working. Local health and wellbeing boards provide a forum for health and social care leaders to work together at a strategic level. Setting an example in this way should encourage working together throughout the system. Some areas have other opportunities for leaders to meet together, such as quality forums and provider alliances.

> **Key resource**
>
> Different practitioners have their own cultures and languages. Bridging these can be a challenge: there is often a need to change relationships and shift perceptions. SCIE has produced a tool, Integrated working for better practice. It will help you ask questions about what is and is not working in your communication and coordination.

> **Case study**
>
> South Devon and Torbay Clinical Commissioning Group expanded 'community virtual wards' (integrated health and social care teams) across GP practices in 2012. These teams identified people at risk of unnecessary hospital admissions, with the aim of reducing duplication, improving continuity and quality of care across providers and maximising community resources. Proactive case management using the community virtual ward and the Devon Predictive Model (King's Fund resource) explains the system in detail.

Safeguarding

Effective communication is fundamental to safeguarding (recommendations 1.6.1–1.6.6). Sharing information means that safeguarding issues are more likely to be identified at an early stage. Missed and late visits and a lack of continuity of care can also have a negative impact on safety. It is important to see effective safeguarding as a marker of good care, not as an outcome of poor care.

> **Key resource**
>
> Providers and commissioners' organisational attitudes to, and perceptions of, risk vary. Talking to older people about their experiences is central to effective safeguarding. SCIE's adult safeguarding hub provides guides and learning materials on all aspects of adult safeguarding, including ensuring safeguarding policies and procedures are person-centred.

> CQC Regulation 13 relates to safeguarding people using services from abuse and improper treatment.

Learning, development and support for home care workers

Providing people-centred support helps deliver greater job satisfaction for the workforce. This is because workers are able to establish and develop relationships with people and support good outcomes.

> **Key resource**
>
> The Skills for Care Workforce Development Strategy helps employers to develop person-centred values in their workforce.

> CQC Regulation 19 relates to Fit and Proper Persons Employed.

Recruiting

The recruitment process should be fair and transparent (recommendations 1.7.1–1.7.2). Value-based selection processes help to ensure that new recruits have the personal attributes essential to delivering person-centred care. Providers should consider involving people who use home care and their carers when recruiting home care workers.

> **Key resource**
>
> Skills for Care has an online guide to attracting, recruiting, and retaining home care workers. It includes information on maintaining a person-centred workforce.

Learning and development

The Care Certificate, developed by Skills for Care, is a set of standards that social care and health workers follow in their daily working life. The standards should be covered as part of induction training for all new care workers. The Care Certificate includes a standard for working in a person-centred way.

A skilled home care workforce supports the idea of home care as an attractive career with a defined professional identity. To cultivate a stable workforce, providers should consider current and future training needs.

> **Key resources**
>
> Relevant specialist training providers include Action On Hearing Loss; Alzheimer's Society; Dementia Gateway (SCIE); Diabetes UK; Headway; Macmillan Cancer Support; Marie Curie Cancer Care; Mencap; Motor Neurone Disease Association; Multiple Sclerosis Society; Parkinson's UK; RNIB; Royal Association For Deaf People; SCOPE; Sense; Spinal Injuries Association; Stroke Association.

> Consider using training providers who have signed up to the Social Care Commitment.

Networks of support

Frontline home care workers can find the job isolating. They may feel unsupported in their role if they are not easily able to seek advice and support from their manager and peers. It is important that an organisation offers direct and indirect support networks to increase self-esteem, promote reflection and critical thinking, and encourage resilience among frontline workers.

Care diaries are one way to help home care workers feel less isolated, but organisations should offer proactive managerial support, too. Protecting time for frontline workers to meet and share both positive and difficult experiences is part of employee support. Ensuring other practitioners (for example, social workers, community nurses, occupational therapists) can offer support to the home care workers will help build on person-centred values, as well as equipping home care workers with the knowledge and skill to deal with complex care.

> **Key resource**
>
> Home care workers should be supervised at least every 3 months (recommendation 1.7.12) and have an agreed written record of the supervision. SCIE has produced a guide to help employers provide effective supervision in a variety of settings.

Providing information and resources

The guideline states that everyone who is using, or planning to use, home care services and their carers should be given details of different funding mechanisms, information about the range and quality of services, what home care is (and is not) able to address and any other relevant options. This includes information on complaints procedures. A 'welcome pack' for people who have recently begun to use home care may include this, plus information on local and national services.

Table 1 – when to provide information

This table (from Research in Practice for Adults) shows the different types of information that should be available at different times of a social care journey.

Before contact	Contact	Assessment	Care and support
• Maintaining well-being • Self-care	• Access to universal services (leisure, transport, etc.) • How to raise concerns about safety or well-being	• Financial planning	• How care and support works
	• Signposting to low level care and support • Advocacy • How to contact in future	• Signposting to other agencies	
		• Eligibility • Support planning	• Planning ahead • Paying for care

			• Crisis options
			• Care and support options
			• Quality of care and support
			• Contingency
			• Feedback

Key resources

The Care Act 2014 places a responsibility on local authorities to ensure the availability of information and advice relating to local care and support for adults and support for carers. It is good practice, and mutually beneficial, for local authorities to ensure home care providers are fully aware of all relevant local services.

The information for the public is written for people using home care services and their families and carers. It uses simple language to explain what care they should expect and how the NICE guideline should make a difference to their care.

Community capacity

Community resources are not limited to formal services. They include lower-cost and free activities and are related as much to people's interests as to their needs. A community can also provide a valuable preventive role (see the SCIE prevention library) and help with safeguarding.

Home care providers and local authorities should hold a bank of knowledge on community resources, and they should share this information as widely as possible. This is so they may effectively point people towards the resources that will be most useful to them, taking into account the person's preferences, interests and abilities.

Key resource

The Care Act (2014) requires communities to build their capacity. This involves making use of resources that already exist – such as neighbourhood groups and befriending schemes – and developing new ones. It helps people find ways of meeting their own needs, and the needs of others, in the place where they live. Think Local Act Personal has information on building community capacity.

About this tool

This tool is based on the NICE guideline on home care published in September 2015. It was written with advice and feedback from:

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