Towards Safe, Effective and Compassionate Care – Guidelines Supporting Domiciliary Care Workers to meet the NISCC Standards of Conduct and Practice

March 2017

Contents Page

Introduction

The domiciliary care workforce in Northern Ireland is often described as the cornerstone of community care. Domiciliary care is a vital service delivering over 250,000 hours of care provided to on average, 23,000 service users each week throughout Northern Ireland at a cost of approximately £204 million per annum. [1]

There are currently 304 domiciliary care agencies registered with the Regulation Quality Improvement Authority (RQIA) employing approximately 11,000 domiciliary care staff across the statutory and independent sectors.

Domiciliary care workers are employed across a varied range of service provision within statutory, voluntary and independent sector organisations, to provide support to the most vulnerable living at home. These include children, young people, adults and older people who require care and support to continue to live safe and healthy lives in their communities.

Domiciliary care is defined as the range of services put in place to support an individual in their own home. Services may involve routine household tasks within or outside the home, personal care of the service user and other domestic services necessary to maintain an individual in an acceptable level of health, hygiene, dignity, safety and ease in their home.[2] Increasingly the role has required the provision of personal care to people with complex needs.

The role of domiciliary care is an increasingly important one given our ageing population. The numbers of people over 65 years of age is projected to rise to constitute 45% of the overall population by 2030. The majority of care (80%) is provided to the 65+ age group.

Most service users will choose to remain living in their own homes for as long as possible[3]. Good preventive services reduce the need for admission to acute hospital and other forms of institutional care. Domiciliary care workers are often the first and main point of contact for many vulnerable service users and so are key to facilitating the 'home as hub'[4] policy agenda.

[1] Domiciliary Care Workforce Review (Northern Ireland) 2016-2021
[2] Domiciliary Care Services for Adults in Northern Ireland (2014), Information Analysis Directorate, DHSSPSNI
[3] Transforming Your Care, A Review of Health and Social Care in Northern Ireland, December 2011

Social care and health care systems are inextricably linked with domiciliary care often both supporting the prevention of hospital admission and facilitating timely discharge. Domiciliary care workers are often increasingly involved in delivering on the reablement agenda through step up and step down schemes.

There will be a greater demand for support as levels of disability and dependency increase with age. It is imperative therefore that this workforce is skilled and trained with the ability to adapt to meet the needs of current and future service users. This will require a flexible workforce which can meet agreed need within the context of individual choice and control.

In June 2015, the then Minister for Health, announced the roll-out of compulsory registration for the domiciliary care workforce. The registration process for this workforce is due to be completed by March 2017. As of 31st March 2017, there were 30, 478 social care workers on the NISCC Register, including almost 8,000 domiciliary care workers across 500 employers. The estimated number of domiciliary care workers at the end of roll-out will be in the region of 11,000.

Workforce regulation plays an important role in driving up standards of care and improving practice, and also addressing poor practice. It also serves to promote social care as an important and credible career.

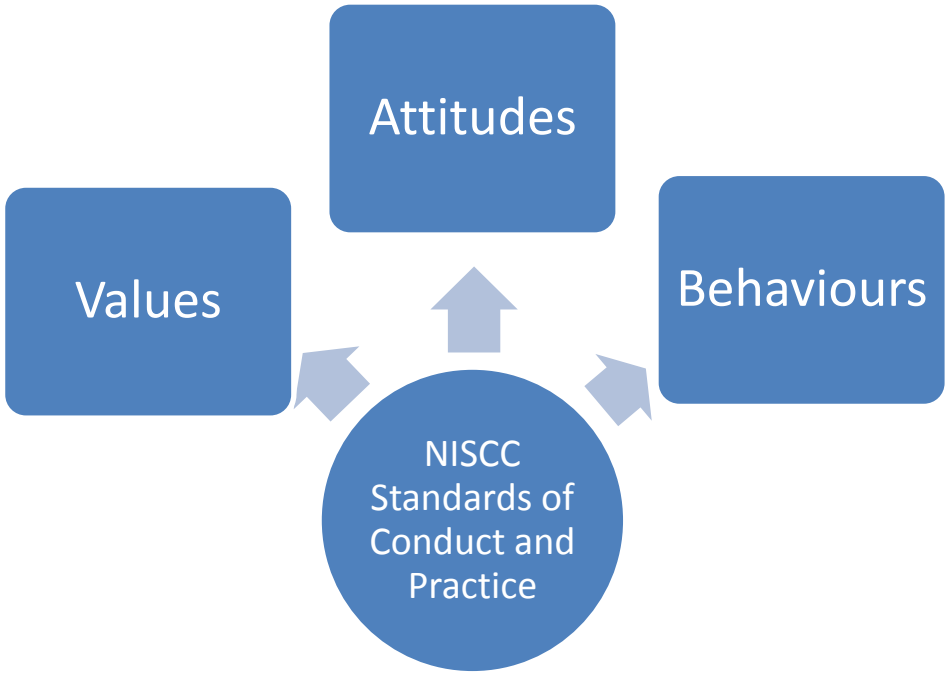
As part of maintaining their ongoing registration with the Northern Ireland Social Care Council, all registrants must agree to adhere to the Standards of Conduct and Practice for Social Workers and Social Care Workers. These standards describe the values, attitudes and behaviours expected of registrants as well as the knowledge and skills required for competent practice. The standards are intended to reflect existing good practice and both professional and public expectations of the behaviour and practice of social workers and social care workers. They form part of the wider package of legislation, regulatory requirements, practice standards and employers' policies that this workforce must meet.

The following values inform and underpin the standards of conduct and practice:
Social care workers must:

[4] Transforming Your Care, A Review of Health and Social Care in Northern Ireland, December 2011

- Respect the rights, dignity and inherent worth of individuals
- Work in a person-centred way
- Treat people respectfully and with compassion
- Support and promote the independence and autonomy of service users
- Act in the best interests of service users and carers
- Uphold and promote equality, diversity and inclusion
- Ensure the care they provide is safe and effective and of a high quality

Figure 1 below depicts the interface between the standards and the values, attitudes and behaviours they require:



The standards provide the regulatory framework against which a registrant's fitness to practise will be assessed if someone raises a concern about their conduct or practice.

It is essential that domiciliary care workers as new registrants with the Northern Ireland Social Care Council understand the responsibilities that come with being part of a regulated workforce. Employers and managers play a key role in supporting registrants to meet regulatory requirements.

This guideline is intended to support social care employers, specifically supervisors, managers, learning and development leads in ensuring that domiciliary care staff they

employ are enabled to meet the NISCC Standards of Conduct and Practice. It can be used as a development tool for managers to help them consider the behaviour of frontline staff, to recognise how staff behaviour has implications for the workplace; lastly it identifies approaches that can be used to strengthen social care practice. Checklists throughout the document and in the appendix are intended to be used as prompts/cues for reflection. It can also be used directly with staff as a tool to enhance supervision on an individual basis or collectively within a team.

Methodology

Who is the Guideline Intended For?

The guideline is relevant to the social care workforce, predominantly the domiciliary care workforce employed within the statutory, voluntary and independent sectors. It will be of use to employers particularly managers and those who are responsible for workforce development.

Terms of Reference

The Terms of Reference were developed by the Guideline Development Group (GDG). These guidelines aim to outline the most effective strategies for maintaining and developing good social care practice. Linked to a range of roles and functions social care registrants and their employers will be able to contextualise the NISCC Standards of Conduct and Practice within the context of their day to day practice.

Objectives

- To review the current local, national and international evidence for promoting and sustaining positive behaviour and adherence to professional standards among those working in domiciliary care and comparable roles in healthcare provision.
- To develop a guideline based on the current evidence in conjunction with an expert panel of social care sector representatives, service users and carers
- To disseminate guidelines to social care employers in NI.

Needs Assessment

Registration for the domiciliary care and day care workforce is being rolled out across all settings and employer groups in advance of this being a mandatory requirement from 1st April 2017.

The NISCC Standards of Conduct describe the values, attitudes and behaviours expected of social care workers in their day to day work. The Standards of Practice describe the

knowledge and skills required for competent social care practice. The regulation of domiciliary care workers aims to not only protect the public, but also to raise the standards of this workforce.

There are no existing guidelines in place for the domiciliary care workforce in relation to the NISCC Standards. While other jurisdictions have generic guidelines for domiciliary care workers in place, these are not aligned to the NISCC Standards which are country specific in nature. Northern Ireland is the first country in Europe to introduce compulsory registration for the domiciliary care workforce.

Involvement of Stakeholders

The involvement of relevant professional and service user and carer organisations is key to the development of GAIN guidelines, (see 'Advice for Guideline Development in Northern Ireland' document). A list of the GDG for 'Towards Safe and Effective Care – Guidelines Supporting Domiciliary Care Workers to meet the NISCC Standards of Conduct and Practice' can be found in Appendix 2.

Who Developed the Guideline?

This guideline was developed by a team of social care professionals, service users and carer representatives known as the Guideline Development Group (GDG) and supported by GAIN. In the process of developing this guideline the information was tabled at the Employers Advisory Group and the NISCC Participation Partnership at meetings during 2016/17. A number of workshops were held to enable social care organisations to contribute views and comments to help refine the draft guideline, (see Appendix 3). The basic steps in the process of developing a guideline were also taken from Appendix 5 of the 'Advice for Guideline Development in Northern Ireland Manual' (GAIN, 2014).

The Guideline Development Group

The GDG for the 'Guideline Supporting Domiciliary Care Workers to meet the NISCC Standards of Conduct and Practice' was recruited in line with existing GAIN protocol. Following funding approval by the GAIN Committee requests for nominations were sent to the main stakeholder organisations as well as the NISCC Participation Partnership. The guideline development process was supported by GAIN staff. At the start of the guideline

development process all GDG members' interests were recorded on a standard declaration form that covered consultancies, fee-paid work, share-holdings, fellowships and support from the healthcare industry.

No conflicts of interest were declared during the development of this guideline.

Guideline Development Group Meetings

Bi-monthly meetings were held between July 2016 and February 2017. The Chair divided the GDG into two groups (Steering and Working Groups), which had social care employers on each group. Workshops were arranged with a number of organisations in order to better ensure involvement and engagement of employees and employers. The guideline was developed as a result of an in-depth iterative process, which utilised knowledge and a range of robust evidence.

Service Users and Carers

Key to the development of the guideline was the involvement of service users and carers. In order to achieve this aim, the knowledge and skills of the NISCC Participation Partnership (Partnership) were utilised. The Partnership meet every six weeks and their role is to advise, challenge and assist the work of NISCC. A member of the group contributed through their attendance and involvement on the working group and the guideline was scheduled on the agenda of the Partnership meetings for consideration and discussion at their meetings during the duration of the development of this guideline.

Expert Advisors

During the development phase of the guideline, the GDG identified areas where there was a requirement for expert input on particular specialist topic areas. These topics were addressed by one of the expert GDG members who brought the additional evidence to the table for the group to discuss and agree.

Peer Review

The guideline was peer reviewed by an academic who has published extensively in the area of mental health policy and an Assistant Director for Adult Services with lead responsibility for strategic management of domiciliary care services for older people and people with a physical disability.

Dr Wilson's main research interests are in social work education and mental health policy and practice. He has published extensively in both these fields. Dr Wilson has a special interest in comparative research and he has been involved in a number of studies that have focused on social work educational policy and practice in Northern Ireland and the Republic of Ireland. Dr Wilson was formerly Programme Director of the MSc in Strategy and Leadership (Social Work) in Queen's University, Belfast and currently works as an independent researcher and part-time tutor at Queens.

Updating the Guideline

In keeping with GAIN requirements, these guidelines will be reviewed in 2020 or sooner in light of any emerging new evidence.

Funding

The GDG was commissioned by GAIN to develop this guideline.

Clinical Audit

It is important that the implementation and usage of this guideline is continually monitored using the clinical audit process. Key areas identified within the guideline should be audited across each Trust area using a generic clinical audit tool to ensure consistency of approach. This should take place on a yearly basis.

Literature Review

It was decided that a narrative literature review was the most appropriate approach to the development of the guideline. This type of review critiques and summarises a body of literature and draws conclusions about the topic in question. The following steps were followed to ensure a robust approach:

- Selection of review topic
- Search of the literature
- Gathering, reading and analysing the literature

Selection of Review Topic

The review topic was agreed at a meeting of the GDG where suggestions and ideas were used to formulate a literature search plan. The search plan was piloted in consultation with a librarian from 'Health on the Net Northern Ireland' (HONNI). Initial attempts were made to identify and select the evidence and to sift in accordance with inclusion and exclusion criteria. This resulted in limited retrieval in terms of relevant evidence.

Members of the GDG worked alongside two Research Fellows at QUB to review and enhance the search strategy. Following consultation with a trial search co-ordinator in School of Social Sciences, Education and Social Work, Queen's University Belfast, search strategies were used for the following databases; CINAHL, Psychinfo, Social Services Abstracts and Sociological Abstracts.

The literature review retrieved papers which related to the following criteria: studies that identified strategies/motivations for promoting and sustaining positive behaviour and adherence to standards and codes among paraprofessional workforce.

The initial search was carried out on the 07 November 2016. A total of 1,161 articles were retrieved. The first stage of sifting through search results and selecting relevant studies on the basis of title gleaned 251 articles for possible inclusion in literature review. For breakdown of article inclusion by database, see Appendix 3.

The next stage was carried out on the 09 November 2016 and involved a collective sift and selection of relevant studies for inclusion based on abstract and where necessary,

examination of the full text. This stage narrowed the number of articles to 158. The breakdown of article inclusion by database is noted in Table 1.

Inclusion/Exclusion

Exclusion criteria were based on the scope of the review. Those studies that did not seek to identify strategies/motivations for promoting and sustaining positive behaviour, adherence to standards/codes among paraprofessional workforce were excluded, as were studies that did not identify approaches to effect behaviour change/attitudes and values/ knowledge and skills/ confidence.

Findings of the Literature Review

Across the professions of nursing, teaching and social work, initial sifts indicated recurrent themes on burnout, stress, work demand, satisfaction, employee health, attitudes and experiences, awareness and knowledge, organisational factors, compliance/adherence to standards, morale/empowerment, organisational culture, methods of learning/teaching strategies/interventions, training and supervision. The findings of the review are summarised in table 2 outlining the themes associated with social care practice alongside the risk or outcome of the theme and a potential strategy to optimise good social care practice. The full literature review is available at https://www.rqia.org.uk/what-we-do/gain/gain-guidelines/.

Theme	Risk/Outcome	Strategy
Stress and Burnout	Negative attitude to care recipients, negative impact on care	Supervision, training programmes focussing on burnout, strategies to promote hardiness
Retention	Inconsistent care	Management style, employee income, education, career progression
Empowerment	Increased, performance, satisfaction	Employee empowerment through participative management and employee involvement, empowered work teams, increase self-esteem of staff
Satisfaction	Staff turnover, reduced levels of care	Work environment, specific skill enhancement e.g. dementia, social, managerial, personal relationships, positive relationships with service users and carers, permanent monitoring of job satisfaction, workload, adequate resources, organisational structures, work based opportunities for achievement and recognition
Staff Attitude	Moral disengagement, reduced adherence to ethical codes	Training, need to challenge stigma and devaluation of care work (dignity at work), positive emphasis on person centered approaches
Environment	Quality of care	Regular assessment of the quality of a work environment to ascertain potential for improvement, cultural change, developing communities of practice, reduction of worker isolation
Adherence/ Compliance	Non Compliance	Information alongside educational activities, role models, mentors, development of a compliance plan, compliance culture based on ethical and honest core values, zero tolerance of fraud and abuse and an emphasis on ethical behaviour , honesty and integrity

Supervision/ Mentoring/Skills Training	Quality of care, moral distress	Supportive, developmental supervision, mentoring, modelling, employee involvement in design of training, interactive learning, role-play, workshops, short frequent training inputs, positive reinforcement of skills, rehearsal of skills, feedback, trainer reflection, translating training into practice, culture of learning, focus on those with lower levels of skills development, whole organisational approaches, whole workforce approaches to training

The Professional Standards Authority report ‘Rethinking Regulation’ (2015), highlights the need for regulators to shift to a stronger focus on preventing harm and to develop a better understanding of how to influence the behaviour of registrants.

The literature review highlights the multi-faceted nature of how behaviour in the workplace is shaped and how positive behaviour can be optimised in place of behaviour that is likely to have negative care outcomes for those in receipt of social care. Whilst the focus of this guideline is on the domiciliary care workforce, the findings of the literature review have relevance to other staff groups within health and social care. The next section presents the guideline, a behavioural framework for delivering on Standards of Conduct and Practice (NISCC Standards), by building on positive behaviours and addressing behaviours that have the potential to contribute to negative care outcomes for those in receipt of care. The guideline is informed by the Behaviour Change Wheel (Michie et al, 2011) and the findings from the literature review.

A Model for Supporting Staff to Deliver on the Standards of Conduct and Practice

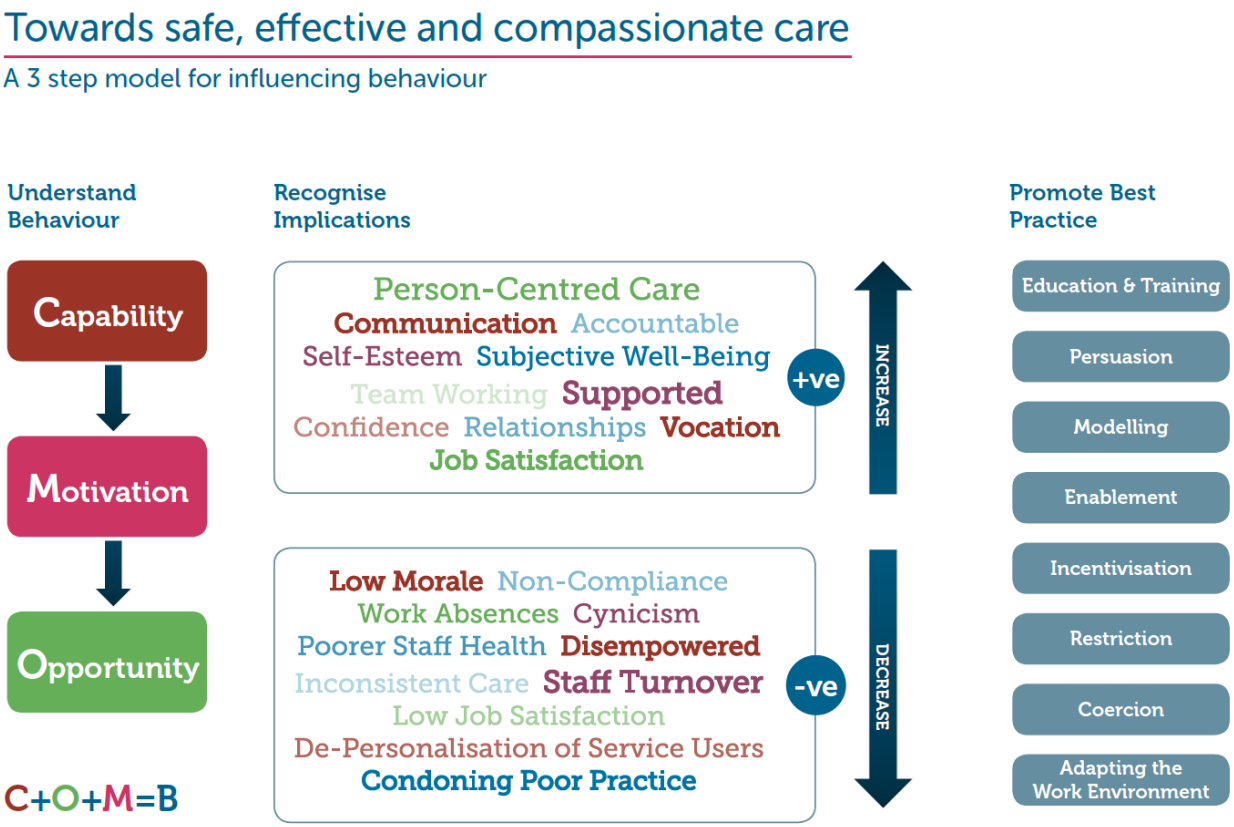
Figure 2 (below) provides an illustration of the model that underpins this guideline. It has been heavily influenced by the work of Michie et al (2011) who developed the Behaviour Change Wheel, components of which will be referenced within this section[5].

The model is outlined in three steps.

Step 1 - provides an explanation of what influences staff behaviour (**understand staff behaviours**).

Step 2 - demonstrated within the context of social care, it details the implications that different behaviours can have on practice including signs suggestive of good practice as well as poor practice (**recognise implications of behaviour for the workplace**).

Step 3 - the guideline outlines approaches that can be used to optimise positive behaviour and address undesirable behaviours (**promote best practice**). Checklists are provided for social care employers to use as prompts to aid self-assessment.



[5] The Behaviour Change Wheel (BCW) was developed from 19 frameworks of behaviour change identified in a systematic literature review. It can be accessed at http://www.behaviourchangewheel.com/

How to Use the Guideline

This guideline can be used as a tool to influence workforce development. As a manager or supervisor you can use it in the context of supervision and performance management to understand and respond to individual staff and teams. As a senior manager it can be used as a quality assurance mechanism.

Figure 3

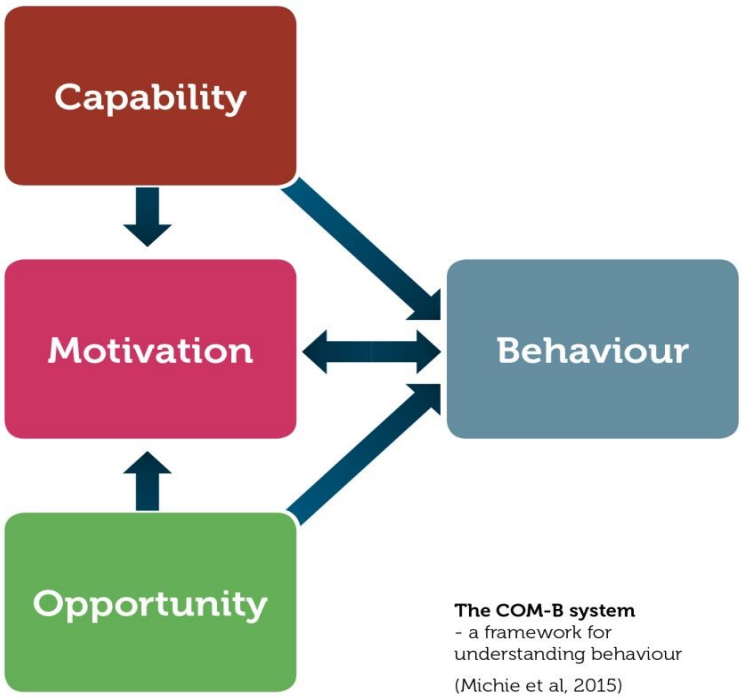
An explanation of each step is provided along with checklists to be used as a reminder or prompt that will help consider how to ensure best practice.

Step 1- Understand Staff Behaviours

The first step in maintaining and developing good social care practice is to understand how staff behaviours are influenced. It is essential to recognise and celebrate excellent behaviour and to prevent the potential for poor, undesirable behaviour. Behaviours do not happen spontaneously, nor do they exist in a vacuum, rather; they are best understood within the context in which they occur. The following figure specifies how a person's behaviour can be influenced by **capability**, **motivation** and **opportunity**. They interact as illustrated by the arrows; therefore increasing opportunity or capability can increase motivation. Increased motivation in turn can lead people to do things that will increase their capability or opportunity by changing behaviour.

Step 1 checklists below can be used as a prompt to help understand the varied aspects of staff behaviour and the origins of behaviours that have the potential to cause concern.

Figure 4 - The COM-B system – a framework for understanding behaviour (Michie et al, 2015)



The COM-B system
- a framework for understanding behaviour

(Michie et al, 2015)

CAPABILITY

- Knowledge and Skill development
- Memory, attention and decision making
- Behavioural regulation
- Capacity to learn

Example - e.g. learn how to provide personal care with dignity and respect

MOTIVATION

- Professional role and identity
- Emotions
- Goals, intentions & beliefs
- Beliefs about consequences
- Reinforcement
- Optimism

Example – compelled to do your job well

OPPORTUNITY

- Environmental context
- Resources
- Social influences

Example – The workplace supports delivery of person-centred care

Step 1 – Checklists

Capability	Examples to understand capability within the workplace	Tick
➢ *Knowledge and Skill development* ➢ *Memory, attention and decision making* ➢ *Behavioural regulation* ➢ *Capacity to learn*	Description of the knowledge, skills and values required for the role?	
	Completion of the NISCC Induction Standards (for new members of staff)	
	Personal Development Plan in place outlining areas for development (knowledge, skills, values). Is it SMART (specific, measurable, attainable, realistic and timely)? Does it reflect the individual's identified learning style? Is it regularly updated and reviewed? Does it focus on both acquiring knowledge and the demonstration of skills and values in the workplace?	
	Has the manager or someone else observed demonstration of knowledge, skills and values within the workplace to test out capacity to learn?	
	Is there any cognitive, physical indication that the social care worker has memory, attention difficulties that may affect decision making?	
	If yes to above, is there a learning plan in place to ensure delivery of safe and effective care is not compromised? And have suitable supports been identified and put in place to support the worker?	
	Do they pay attention to task, persist when it becomes difficult, demonstrate flexibility and be confident that additional effort will lead to positive outcomes?	
	Does the staff member set their own goals and direct their learning to achieve their goals?	
	Do they demonstrate the ability to meet personalised learning objectives and key performance indicators as part	

	of supervision and performance appraisal processes?	
	Do they demonstrate the ability to balance organisational and task requirements with a sensitive and person-centred approach?	
	Can they self-reflect and make adjustments to their practice?	
	Can they monitor and regulate their moods, feelings and emotions when at work alongside managers, colleagues, service users?	
	Has the manager or someone else completed a competency assessment to evidence integration of learning into direct practice with service users?	

Motivation	Examples to understand motivation within the workplace	Tick
MOTIVATION ➢ *Professional role and identity* ➢ *Emotions* ➢ *Goals, intentions & beliefs* ➢ *Beliefs about consequences* ➢ *Reinforcement* ➢ *Optimism*	Do they have an appreciation of professional role and identity as a regulated social care worker?	
	Do they have confidence about their capabilities?	
	Do they have a realistic view about their capabilities?	
	Do they have a positive outlook for their service users and carers and the service provided?	
	Do they understand what could happen if they fall short of the NISCC Standards?	
	Do they articulate an intention to do the best job that they can do, provide the best service possible for the service users and carers?	
	Have they set, agreed development/career goals?	
	Do they use their initiative to develop their own knowledge and skills?	
	Do they understand the importance of positive reinforcement?	
	Do they act on feedback whether positive or negative in a constructive manner to further their goals and professional development?	
	Do they appear to be emotionally connected to their work?	
	Can they recognise when to ask for support if they are overwhelmed or dealing with complex or difficult practice issues?	
	Can they recognise when personal issues have the potential to impact on role and seek support as appropriate?	

Opportunity	Examples to understand opportunity within the workplace	Tick
➢ *Environmental context* ➢ *Resources* ➢ *Social influences*	Do they have sufficient resource to carry out their role?	
	Do they have sufficient learning and development opportunities?	
	Is there a positive line management and senior management culture (demonstrating respect, valuing staff)?	
	Do they have formal structures for supervision and reflection?	
	Do they understand their role within the physical space in which it has to be performed?	
	Do they change how they behave to be more like others?	
	Do they seek the approval and friendship of others?	
	Do they do something that they are asked to do by another?	
	Is there openness towards the adoption a new attitude, belief, or action?	
	Do they resist the influence attempts of others?	
	Do they understand appropriate professional boundaries with service users and carers?	

The literature review examined the evidence base around effective strategies for promoting and sustaining positive behaviour and adherence to professional standards. The findings of the review inform Step 2, by considering how positive and negative behaviour can manifest in the workplace. The figure above outlines the consequences of behaviours both positive and negative.

Positive behaviours

- At the top of the arrow ***communication*** is highlighted. Employees can experience an increase in morale, productivity and commitment if they are able to communicate up and down the communication chain in an organisation.
- Social care workers are ***accountable*** both as registrants and employees. They account for their practice to their manager and organisation about how legal duties have been used, how dignity and respect has been shown or how conclusions about care have been reached. They are accountable to the public about how they involve service users and carers in decision making. Managers have a key role to play in enabling staff to think through accountability across these different levels in particular accountability to: public; employer; NISCC; self; manager; team colleagues.
- Staff with higher levels of ***self-esteem*** are more likely to persist in spite of challenges, give their opinions, take initiative, display happiness in the workplace and cope with stress. Managers can build self-esteem by offering regular opportunities for check-in, providing challenging yet attainable goals, giving clear instruction, providing reinforcement, sharing good practice, providing an open door policy, and being approachable .
- It is important to provide staff with opportunities to consider how their sense of wellbeing has the potential to impact their ability to provide care. Managers can provide opportunities for staff to explore their ***wellbeing*** by providing a safe place to probe into emotional health, physical health, sickness and personal issues that may affect work. A focus on well-being at work presents a valuable opportunity to benefit service users by helping staff to feel happy, competent, and satisfied in their roles, to flourish and take pride in their job and to function to the best of their ability, both as individuals and in collaboration with their colleagues.

- Whether working as a lone worker, delivering domiciliary care or working within a supported living context, staff should feel part of a ***team*** within an organisation. A manager has role to play in enabling a 'team environment'. Positive indicators include working well together, valuing being part of a team, having a flexible approach and working collaboratively to place service user at the centre of social care delivery.
- Social Care is a challenging yet rewarding profession. The vast majority of social care staff approach their work with a sense of ***vocation***, a strong feeling that social care is the career for them. To help prospective staff test out their motivation to work in care NISCC has worked in partnership to develop the AQCCY Resource (A Question of Care - a Career for You?) http://www.aquestionofcare.org.uk. AQCCY is designed to 'test drive' someone's suitability to work in care and to find out what the sector is like. It provides a detailed personal profile that can inform a decision about entering care and remaining within the care industry and is therefore a useful tool pre recruitment as well as post recruitment. In addition, the NISCC Ambassador Scheme aims to improve public awareness of social care as a rewarding vocation. To find out more about the scheme visit the NISCC website www.niscc.info/careers.
- ***Satisfaction*** with work and in work featured strongly in the literature. Manthorpe (2014) highlighted the importance of positive relationships in ensuring satisfaction including the development of ***positive relationships,*** relationships with management, with service users and their families as well as social and personal relationships. Other factors pertinent to job satisfaction include job content, responsibility as well as independence and professional growth.
- With an emphasis on 'doing with' rather than 'doing to', ***person centred care*** represents a shift from professionals deciding what is best for a service user, and places the person at the centre, as an expert of their own experience. The person and their family where appropriate, becomes an equal partner in the planning of their care and support, ensuring their needs, goals, and outcomes are met. This approach can improve both the experience and quality of care.
- It is important that staff feel they are ***supported.*** Check out what this means to the individual, their perceptions of how they are best supported. Supervision is a formalised mechanism to offer support. It involves making the time and developing the practical structure to give support to staff. A supervisory relationship is one in which a person with some knowledge and skill, takes responsibility and

accountability for the wellbeing and work performance of the person being supervised, the supervisee and is supportive rather than judgemental.

- The development of knowledge and skills builds ***confidence*** and competence. Confidence can be maintained by providing positive feedback from managers.

Negative behaviours

- Compliance is closely linked to the quality of the work environment. ***Non-compliance*** is reduced where there is constant reinforcement of ethical behaviour and zero tolerance of poor or abusive care practices.
- Retention of social care staff has been identified as a growing problem across the sector. Organisational and managerial factors are key influencing factors. ***Staff turnover*** is associated with low pay, inadequate benefits, lack of respect, poor management, work or family conflicts and the physical and emotional demands of work. Factors promoting retention include having a sense of vocation, feeling able to provide a good standards of care, forming strong relationships with service users and their families and job flexibility. Retention is also enhanced when there are clear pathways for career development, supported through induction, training and supervision. Regular assessments of the quality of work environments in a bid to ascertain potential for improvement, as well as subsequent evaluations of improvement strategies are an important part of recruitment and retention practices.
- Findings from the literature review highlight that ***low job satisfaction*** is one of the main causes of staff leaving care jobs, as well as a lack of appreciation and the workers' own dissatisfaction with the care they were able to provide. Resource adequacy is also a critical determinant. Investment in training, renovation of organisational models and permanent monitoring of job satisfaction are suggested as key strategies to enhance job satisfaction. Staff who report better workplace characteristics in terms of decision authority and variety, also report increased job satisfaction. Establishing communities of practice can provide staff with opportunities to discuss their practice and any challenges or difficulties they are experiencing. This can in turn reduce feelings of isolation.
- Staff can feel ***disempowered*** where they consider they do not have any control or influence over work processes, decisions and outcomes. Findings suggest that feedback from line managers, trust in management and information exchange are all positively associated with shared decision making. Empowerment plays a key role in job satisfaction and career commitment and is linked to there being work-

based opportunities for achievement and recognition. Staff who are empowered to work autonomously have been found to report higher levels of work satisfaction, subjective wellbeing and psychological health. Participative styles of management with a focus on shared decision making and employee involvement.

- Findings suggest that health and social care professionals can sometimes bypass moral and ethical codes and morally disengage in their daily practice. This can result in dissociating and distancing ones elf from the work context and work practices even where these practices are poor or indeed abusive. This ***condoning of poor practice*** is highlighted in several recent inquiries, e.g. the Francis Inquiry into the Mid Staffordshire Hospital Trust.
- Social care is a physically and demanding work role which requires high levels of personal resilience. The role of social care workers has evolved from one of providing principally domestic care to one that involves the provision of domestic, personal and healthcare among a population with evermore complex health and social care needs. Stress and burnout can lead to high levels of exhaustion and cynicism and low levels of efficacy leading to poorer staff health and subjective well-being. Health affects work and work affects health. Employers need to develop strategies to promote resilience among their workforce to make them more resistant to stress and burnout and to have preventative staff support measures in place to reduce ***work absences***. Supervision and training are identified as mitigating factors.
- ***Depersonalisation of service users*** describes a lack of feeling and an uncaring response to service users. There is a strong correlation with emotional exhaustion and poor supervision. Staff who feel they put more into the job than they get out are more likely to detach themselves emotionally from their work leading to the depersonalisation of people using the service (Thomas and Rose, 2009). This is less likely to occur where staff have a sense of personal accomplishment in their work.
- Stress and ***low morale***, resulting from the way that social care staff are treated, can have a direct impact on service quality and cost. The first step in dealing with low staff morale is to recognise those who may be vulnerable. It is important to afford staff the opportunity to air their views and to encourage their participation in significant projects. Structured appraisal systems can also be helpful.

All of the above behaviours can result in poor and ***inconsistent standards of care*** and lack of continuity for service users. An organisational culture that promotes prevention, detection and resolution of instances of poor practice/misconduct is essential to ensure the provision of high quality social care.

Step 3 - Promote Best Practice

Steps 1 and 2 have been designed to help understand behaviour and to help recognise how positive behaviour is demonstrated in the workplace.

Step 3 aims to highlight a range of approaches that can be used to maximise positive behaviour and adherence to the NISCC standards.

Many of these approaches are commonplace within social care. The table below seeks to apply nine approaches to a social care context:

Approach	Definition	Example
Education and training	Increasing workers' knowledge or understanding in relation to their roles, responsibilities or service user group. Imparting skills	Providing an induction programme for all new entrants to the workforce
Persuasion	Using communication to promote positive behaviour; encourage action	Notices, signs in communal staff areas, for example, to promote good hand hygiene
Modelling	Providing a best practice example for workers to aspire to or imitate	Providing opportunities for workers to shadow or work alongside more skilled and experienced staff
Enablement	Empowering the worker to take more responsibility for and ownership of their behaviour. To increase their ability to influence decisions or practice	Providing opportunities for workers to input to assessment, care planning and review processes
Incentives	Offering a reward or benefit as a result of a particular behaviour	Staff Award schemes
Restriction	Using rules or regulations to reduce undesired behaviour or to promote desired behaviour	Operational policies and procedures that set out expected behaviours and consequences of non-compliance

Coercion	Creating an expectation of consequence, sanction for undesired behaviour	Disciplinary policies
Adapting the work environment	Changing the physical or social care environment to encourage the required behaviour	Technological supports to enable lone workers to keep in touch with their work base

In promoting these best practice approaches you can select from the menu above based on what you consider to be the best fit for your service and for staff. Each approach is further explained in **Step 3 checklists**. They have been developed based on the findings from the literature review.

The following criteria can be used to help select the most appropriate approach.

Possible considerations	Yes/No	Reason
Is the selected approach affordable?		
Is selected the approach practical?		
Who is it for i.e. individual/staff group?		
Is the selected approach effective/ cost-effective?		
Is the selected approach acceptable to employer/staff?		
Are there likely to be any negative outcomes, i.e. unintended negative consequences?		
Is the selected approach fair?		

Step 3 – Checklists

Education and Training **(Operational considerations for First Line Managers/Supervisors)**	**Y/N**
Orientation/induction training upon job entry? *e.g. NISCC Induction Standards, mandatory training*	
Staff involvement in the design of education and training programmes? *e.g. training that recognises and utilises experience of staff*	
Is it directly relevant to the work role?	

e.g. training that equips staff with the specific knowledge and skills that they need for the job	
Are there opportunities to apply the new learning to practice? *e.g. opportunities that enable the new learning to be applied in a timely manner and reinforced so that it is not lost*	
Is there on-the-job learning? *e.g. opportunities to observe skilled practice through demonstration, shadowing or role play*	
Is there positive reinforcement of skills? *e.g. through supervision/observation*	
Are messages continually reinforced? *e.g. through ongoing training, team meetings, posters in staff rooms*	
Is there a focus on problem-solving, stress management and working as part of a team? *e.g. group exercises that encourage staff to work as part of a team towards solving a problem?*	
Is the training interactive? *e.g. opportunities for staff to participate through discussion, case studies, group exercises and feedback*	
Are there in-built opportunities for worker reflection? *e.g. both during and after training inputs and on an on-going basis through supervision, team meetings*	
Are the inputs short and frequent? *e.g. built in to day to day practice and constantly reinforced*	
Are there opportunities to offer feedback to staff on their performance? *e.g. through supervision and appraisal processes or peer mentoring*	
Does the training make use of a range of learning methods? *e.g. formal taught inputs as well as case studies, group exercise, role play, videos, e-learning*	
Is there recognition of differing levels of formal education and experience? *e.g. less reliance on written methods for staff who may have basic literacy skills*	
Is there recognition of different learning styles? *e.g. meet the need of 'activists' who like to 'do' and 'reflectors' who like to think*	
Is the learning provision flexible? *e.g. can respond to emerging or changing learning needs*	
Does the training incorporate IT skills? *e.g. provision of on-line learning methods which enable the acquisition of IT skills at the same time*	

Education and Training **(Strategic considerations for Senior Managers)**	**Y/N**
Is there a strategic commitment to education and training? *e.g. is it clearly incorporated in corporate and strategic plans and aligned to business and operational objectives*	
Is there a dedicated and protected budget? *e.g. ring-fenced monies based on identified learning and development plans which will not be used for other purposes*	
Does the training consider the wider social and policy environment? *e.g. key policies such as Transforming Your Care, regulations and guidelines such as RQIA minimum standards*	
Is the training seen to be valued by employers? *e.g. is it prioritised and achievement recognised?*	
Is there a whole workforce approach to learning? *e.g. is there a top/down and bottom/up learning culture?*	
Do those delivering the training have professional competence in the care sector? *e.g. occupational competence and recognised qualifications*	
Is there a formal evaluation of training and the impact it makes on direct practice with service users?	

Persuasion **(convince other people to change their attitudes or behaviour regarding an issue through the communication of a Message)**	**Y/N**
Is there clarity about the message to be communicated? *e.g. is the message clear, unambiguous and likely to be understood by the intended audience?*	
Who is it aimed at? *e.g. an individual, specific group of staff or workforce wide*	
Do staff know the reasons for the desired behaviour/required behaviour change? *e.g. a clear rationale for desired behaviour/change and the source of this is provided to staff at a team meeting*	
Are there external reasons for the behaviour change? *e.g. changes in DOH/RQIA Regulations or Guidelines*	
How is the message delivered? *e.g. verbally at a team meeting; formally by letter*	
Who delivers the message? *e.g. line manager, senior manager, CEO*	

Are signs and visual cues be used to reinforce the desired behaviour? *e.g. posters and notices in staff rooms; or at sinks in relation to hand hygiene*	
Are there high levels of exposure about the message? *e.g. use of a range of methods to communicate and reinforce it*	

Modelling **(Employee training in which they are encouraged to act and respond as their specified role models do in similar situations)**	**Y/N**
Is there a model/definition of what good social care looks like? *e.g. aligned to NISCC Standards of Conduct and Practice, employer policies and procedures, organisational Mission Statement to include philosophy of care, staff handbook*	
Are there opportunities for staff to observe competent and skilled practice? *e.g. from more experienced staff during formal induction; inputs from professional staff such as physiotherapists, speech and language therapists*	
Are there opportunities for shadowing and/or mentoring? *e.g. on the job opportunities both as part of formal and ongoing induction processes*	
Are there workplace champions/ambassadors? *e.g. safeguarding champion within the workplace or participation In NISCC Social Care Ambassadors*	
Are there opportunities for learning about and sharing best practice? *e.g. attendance at conferences, workshops, showcasing events, access to SCIE resources*	
Are there opportunities for staff to belong to a wider practice network? *e.g. Social Care Forums, virtual networks, action learning sets*	
Is there constant reinforcement of ethical and honest core values? *e.g. organisational mission and aims, reinforcement of NISCC Standards, exploration of ethical issues and dilemmas both actual and hypothetical at team meetings*	
Are there opportunities for ethical practice to be embedded into daily practices? *e.g. service improvement, journal clubs, training support groups*	
Is there zero tolerance of fraud and abuse? *e.g. fraud policy, safeguarding policies and procedures and training*	

Enablement (a form of self-improvement to learn new skills or relearn existing ones)	**Y/N**
Are staff involved in decision-making processes? *e.g. improvement initiatives, changes in care practice*	
Are staff able to make an impact on work outcomes? *e.g. involvement in care planning and review processes*	
Are staff encouraged to problem-solve? *e.g. given responsibility and autonomy commensurate with their knowledge and experience to make decisions*	
Are staff given opportunity to take responsibility for quality initiatives/quality improvement ideas? *e.g. recognition and reward schemes for improvement initiatives*	
Are staff able to provide feedback to managers? *e.g. suggestion boxes, team meetings*	
Are staff provided with sufficient information to enable them to do their job effectively? *e.g. procedural manual, access to NISCC apps*	
Are there effective processes to delegate work when required? *e.g. clear lines of accountability established*	
Are there opportunities for self-reflection of skills? *e.g. built in to supervision and appraisal processes*	
Can staff be encouraged to feel part of team even if lone workers? *e.g. access to virtual networks or local staff hubs; staff meetings*	
Are there opportunities to learn via role play and modelling? *e.g. as part of on the job training or in supervision*	
Are staff enabled to develop resilience and positive coping strategies? *e.g. policies which promote an effective work/life balance*	

Incentives/Rewards	**Y/N**
Are there incentives to promote good practice? *e.g. long service recognition*	
Are the incentives realistic? *e.g. affordable and sustainable*	
Are incentives clearly linked to performance? *e.g. clear criteria for incentive schemes which reinforce required behaviours/good practice*	
Have staff been consulted on the incentives? *e.g. staff surveys*	
Are there schemes to recognise and reward good practice?	

e.g. award ceremonies for achievement of awards, qualifications	
Are there opportunities for career progression? *e.g. access to accredited learning and development opportunities; 'acting up' opportunities*	

Restriction (rules which cannot be broken)	**Y/N**
Are there clear operational policies and procedures in place? *e.g. accessible to staff and continually reinforced*	
Are staff aware of external regulations? *e.g. RQIA Standards, NISCC Standards of Conduct and Practice*	
Is there zero tolerance of poor practice and is this communicated to staff? *e.g. disciplinary procedures, whistleblowing policy*	
Are there systems in place for monitoring and evaluating performance? *e.g. formal supervision, performance appraisal*	

Coercion	**Y/N**
Are there consequences/sanctions in place for undesired behaviour? *e.g. disciplinary procedures, referral to NISCC as workforce regulator*	
Are these communicated clearly to staff? *e.g. staff handbooks, staff meetings*	
Are they imposed consistently and equally? *e.g. referral criteria to external regulatory bodies, audit processes*	
Are there external regulations? *e.g. referral to NISCC, RQIA, Adult Safeguarding Team*	

Adapting the Work Environment	**Y/N**
Is there a management structure that is fit for purpose? *e.g. clear accountability and governance structures*	
Is there an effective process to manage workload? *e.g. workload allocation systems, time and motion studies, staff feedback*	
Are there adequate staffing levels? *e.g. in line with RQIA standards and regulations*	
Is there front-line management support for staff? *e.g. supervision, team meetings and ad-hoc support*	
Is there management training?	

e.g. on the job and formal accredited training	
Is the physical environment conducive to enabling staff to carry out their work role safely and effectively? *e.g. health and safety policies*	
Are there zero tolerance policies in relation to abuse of staff? *e.g. public notices and signage*	
Is there provision for staff care? *e.g care call, occupational health, stress management*	
Is there a learning rather than a blame culture? *e.g. learning from near misses, complaints*	

Bringing it all together

It is hoped that this guideline will offer a useful resource to social care employers in supporting them to enable their domiciliary care workforce to meet the NISCC Standards of Conduct and Practice. It is acknowledged that many social care employers already have in place some of the strategies, systems and supports that are recommended in this guideline. The guideline does however seek to offer an evidence-based and whole systems approach to ensuring social care practice is safe, effective and compassionate and compliant with both the NISCC Standards and best practice standards within the sector.

The 3 step model can be used to understand, recognise and promote best practice with the associated checklists offering practical prompts for the implementation of the model. This guideline represents a first step in a continued collaboration with the social care sector to ensure that a newly regulated domiciliary care workforce is equipped to meet the needs of service users and carers and to deliver high quality services.

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Appendix 1 – Abbreviations

GAIN	Guidelines and Audit Implementation Network
GDG	Guideline Development Group
HONNI	Health on the Network Northern Ireland
NISCC	Northern Ireland Social Care Council
PSA	Professional Standards Authority
RQIA	Regulation Quality Improvement Authority

Appendix 2 - Membership of GAIN Towards Safe and Effective Care – Guidelines Supporting Domiciliary Care Workers to meet the NISCC Standards of Conduct and Practice Guideline Development Group

Name	Designation	Organisation
Co-Chairs		
Brenda Horgan	Professional Advisor	NISCC
Helen Mc Vicker	Head of Fitness to Practise	NISCC
Members		
Claudine McComiskey	Head of Domiciliary Care	Southern HSC Trust
Sandra Ewing	Head of Domiciliary Care	Northern HSC Trust
Sharon Butler	Co-Head of Living Options	The Cedar Foundation
Elaine Somerville	Services Manager (Day care, residential care domiciliary care)	South Eastern HSC Trust
Martin McGeady	Head of Homecare	Western HSC Trust
Alistair Fitzsimons	Chief Executive	Mears Health Care
Geralyn Ainsworth	Assistant Service Manager	Shankill Resource Centre Belfast HSC Trust
Geraldine Campbell	Council Member	NISCC
Nicola Porter	GAIN Manager	RQIA
Amanda Jackson	Inspector of Domiciliary Care	RQIA
Fiona Gilmour	Area Manager, Domiciliary Care	Northern HSC Trust
Una Coyle	Training and Governance Officer for Domiciliary Care	Western HSC Trust
Nuala Kelly	Manager Intensive Domiciliary Support Team	Belfast HSC Trust
Meta Keenan	Workforce Development Officer	NISCC
Anne Mallon	Participation Partnership	NISCC
Jackie McCaughey	Area Manager	Mindwise
Robert Mercer	Regional Clinical Audit Facilitator	RQIA
Siobhan Crilly	Regional Clinical Audit Facilitator	RQIA
Peer Review		
Dr George Wilson	Independent Consultant/Researcher	
Liz Leathem	Assistant Director for Adult Services	Bryson Care

Appendix 3 - Workshop Engagement

Workshop Number	Date	Organisation
1	26/01/2017	Bryson Care
2	03/02/2017	Cedar
3	08/02/2017	SHSCT
4	22/02/2017	Mindwise
5	27/02/2017	NISCC Participation Partnership
5	21/03/2017	SHSCT

Appendix - 4 Literature Review Results

Stage 1 & 2 Sifting

Search strategies were developed for CINAHL, Psychinfo, Social Services Abstracts and Sociological Abstracts. The first stage of sifting through search results (total number of articles 1161) and selecting relevant studies on the basis of title only has gleaned 251 articles for possible inclusion in literature review. Breakdown of article inclusion by database is as follows:

Search Strategy	**Results**	**Number selected (Selected for inclusion based on title)**
CINAHL search strategy 1	320	41
CINAHL search strategy 2	15	5
CINAHL search strategy 3	19	0
HMIC Health Management Information Consortium search strategy	16	16
Psycinfo search strategy 1	295	109
Psycinfo search strategy 2	408	57
Psychinfo search strategy 3	35	6
Social Services Abstracts	19	5
and Sociological Abstracts	34	12
Total	**1,161**	**251**

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