

Can Healthcare Assistant Training (CHAT) improve the relational care of older people? A development and feasibility study of a complex intervention

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Scientific Summary

Background

Those over the age of 75 years now account for 24% of all hospital admissions, an increase of 57% over the previous decade with the average hospital stay for this age group simultaneously decreasing from 15.2 to 9.4 days. The quality of healthcare delivered to older people has come under increased scrutiny. There is evidence that patients judge the quality of the care they receive in terms of the relational aspects of care that include dignity, empathy and emotional support as distinct from functional or transactional aspects of care. Healthcare assistants take on an increasing proportion of the direct care of older people in hospital but until recently their training needs have been overlooked.

Study aims

We aimed to:

1. understand the values-based training needs of HCAs in maintaining the dignity of, and affording respectful care to, older patients in acute NHS settings;
2. develop a values-based training intervention for HCAs designed to address the needs of older patients for high quality relational care;
3. assess the feasibility of a cluster-randomised controlled trial to compare the performance of the developed training intervention for HCAs against current training in improving the care of older patients in acute NHS settings.

Methods

Telephone survey

We conducted a telephone survey of all NHS Trusts in England to understand what training as usual looked like for HCAs caring for older people in hospitals in England. We wished to establish the structure, content, and variability of HCA training, and in particular, training in providing relational care of older patients in hospital. Respondents to the survey were those responsible for HCA training within their Trust.

Focus groups and interviews

We conducted focus groups of older people (or their carers) with recent experience of hospital care. The purpose of the focus groups was to understand the care experiences of older people and their expectations of the training HCAs should receive. We conducted semi-structured interviews with HCAs and other hospital staff undertaken in each of the three study centres. The purpose of the interviews with HCAs and members of staff who worked alongside them was to gain insights into staff perceptions of the challenges that HCAs face in caring for older people in hospital and to explore interviewees' perceptions of training needs in this area of care.

Intervention development

A new training intervention for HCAs to improve the relational care of older people was developed: *Older People's Shoes* © (OPS). The training intervention drew on several sources: focus group and interview data, existing evidence from the literature, an expert panel, and learning about the customer care practices of four retail organisations.

Feasibility cluster-randomised controlled trial

We conducted a feasibility cluster-randomised controlled trial and process evaluation. The feasibility trial compared training as usual for HCAs with the new HCA training in relational care of older people, *Older People's Shoes*. The unit of randomisation was hospital ward. Outcomes were assessed at the level of ward, HCA and patient. Patient level outcomes were the experience of emotional care and quality of life during their hospital stay as measured by PEECH and the EQ-5D. HCA outcomes were empathy measured by the TEQ and attitudes towards older people measured by the AGED Inventory. Ward level outcomes were the quality of HCA/patient interaction measured by QUIS. The purpose of the feasibility trial and the process evaluation was to determine the feasibility and viability of a definitive trial.

Process evaluation

The process evaluation was conducted in parallel with the feasibility trial. This consisted of observations of the delivery of the intervention, follow-up interviews with trainers and HCA learners, and learners' evaluation following training.

Results

Telephone survey

A total of 113 of the 161 acute hospital Trusts in England took part in the telephone survey. A third of interviewees reported content within their HCA training induction programme that we considered to be relational care. Only two respondents said that their Trust covered the subject of 'customer care' whilst the majority reported the inclusion of dementia care in HCA induction programmes.

Reported challenges in training HCAs were related to resource limitations, engaging ward managers and the diverse nature of the HCA workforce. The most frequently cited challenge for delivering training to the HCA workforce was getting staff released from wards to attend. Emphasis was placed on induction, much less on on-going training which is typically devolved to ward managers.

Focus groups and interviews

Older people and those who care for older people broadly agreed on the ways that HCA training in relational care could improve the experiences of patients and HCAs. Older people and their carers stressed the importance of HCAs not stereotyping older people, and friendly, approachable staff who are good listeners made a huge difference to patient experience. HCAs and staff who work with and alongside them highlighted the need to learn how to have difficult conversations with patients and relatives and how to avoid projecting work-related stress. Both groups agreed that relational care needs to be

incorporated into other physical care tasks, and that care can only be personal and individual if the person being cared for is known as an individual rather than a patient.

Older people and their carers, as well as care staff felt strongly that, to be effective, HCA learning should be rooted in real patient experiences. Simulating the experience of being an older patient in hospital was considered a potentially powerful learning tool but few HCAs had the opportunity to try this. HCAs wanted learning to build on the assets they bring to the care of older people.

Intervention development

We developed an HCA training intervention 'Older People's Shoes', through a process of synthesising evidence from data collected within phase one of the CHAT study, together with other inputs from recognised experts in relevant fields, existing evidence, and more specifically, life story work and learning from retail sector organisations. We also investigated the content of current initiatives in order to learn from existing tools to avoid overlap and to situate our intervention in the broader context of related initiatives. Carver's framework, which proposes four key elements to experiential education, provided a theoretical basis for the design of the training package. The product was refined through a series of intervention development workshops. 'Older People's Shoes' is a two-day training course for HCAs caring for older people delivered by a trainer. Each day comprises three units: (i) getting into older people's shoes; (ii) getting to know older people; and (iii) learning from customer care. Learning from each unit on the first day consolidated and built upon on Day Two, approximately one week later. Materials created as part of the CHAT study and required to deliver the intervention include a trainee course book, a trainer guide and an online website.

Feasibility cluster-randomised controlled trial

A pilot cluster-randomised controlled trial was conducted on twelve wards in three NHS trusts to assess the feasibility of a definitive trial to compare the newly developed HCA training package (*Older People's Shoes*) with 'HCA training as usual'. Clusters were wards within three acute NHS Hospital Trusts in England with outcomes observed at the level of ward, HCA and patient. Ward level outcomes were observations of the quality of HCA and patient interactions using QUIS. HCA outcomes were empathy as measured by the TEQ and attitudes towards older people measured by the AGED Inventory. We measured patient reported quality of life using the EQ-5D and patient reported experience of care in hospital using the PEECH questionnaire. Twelve wards took part in the study, six were randomised to each arm of the trial (OPS or TAU). We conducted 91 observation sessions during the four-week baseline period and a further 96 observation sessions between weeks nine and 12 post-randomisation. We recruited 112 HCAs of whom 72 completed a baseline questionnaire, 52 completed the first follow-up questionnaire and 40 completed the second follow-up questionnaire. Of 159 eligible patients recruited at baseline and follow-up period, 88 patients returned completed questionnaires. The total estimated cost of the training was £818.20 per HCA, equivalent to an estimated cost of £14.04 per patient.

Although not looking for evidence of effect, the direction of effect, at 8 weeks and to a lesser extent at 12 weeks, for HCAs was in favour of OPS. There was no evidence that mean interaction ratings differed between OPS and TAU wards. After adjustment for baseline differences, the direction of effect was towards more positive TEQ and AGED Inventory scores for HCAs working in OPS wards compared with TAU wards. Of those

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patients returning completed questionnaires, their report of the care they received as measured by PEECH score were similar between the two arms of the trial and to those patients completing questionnaires during the baseline period.

Process evaluation

In course evaluation forms and at interviews HCAs receiving Older People's Shoes training reported the training intervention to be a highly positive experience. In interviews HCAs who had undertaken training also described changes to their approach to working with older people and in the way they thought about their work and older patients. Observations of intervention delivery suggested that while fidelity was generally good, there was an occasional tension with the need to avoid deviating from the trainer guide and the desire to ensure that training delivery was engaging. Trainers and HCA learner interviewees reported that the two-day structure worked well and the practical and interactive elements with Older People's Shoes were popular with HCA learners and trainers alike.

Opinion was divided about particular activities, with the customer care unit the most contentious. The majority of HCA interviewees were able to give examples of changes they had made since attending the training. Trainers enjoyed the experience although some would have liked more time to prepare. Three trainers felt one person could deliver the training, but two was optimal. In terms of feasibility issues, there was variation between centres and wards in the arrangements made for releasing HCAs to attend the training, but HCAs were keen to attend. Ward observations using QUIS were acceptable to the HCAs interviewed and while the questionnaires were acceptable the need to 'generalise' in order to complete the AGED scale was reported as difficult by some.

Conclusions

Based on our findings we draw the following conclusions:

- 1 Training of HCAs in delivering relational care is highly variable between employing NHS hospital Trusts. Most training is received at induction, and training thereafter tends to be devolved to ward level mentorship. The needs of older people are addressed in HCA training but training in relational care does not appear to be a priority. For those with Trust-level responsibility for HCA training, getting staff to be released from ward duties is a challenge.
- 2 For older people and their relatives their experience of hospital care is shaped by the relationships that they have with the staff who care for them. They are aware of the competing demands placed on staff and the pressures they are under but being in hospital can generate a feeling of powerlessness that often prevents older patients asking for help.
- 3 HCAs and other staff are keen to extend their learning in relational care. Training should address HCA learning needs including having difficult conversations with patients and relatives, and ways to manage, and not project, work-related stress. HCAs acknowledge that their work is more rewarding when they have greater knowledge about the lives of the people they care for.
- 4 A training intervention (*Older People's Shoes*) was designed to meet the learning needs of HCAs in delivering high quality relational care of older people. A transparent process of intervention development was undertaken. Structure and

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content were informed by the older people and their relatives, HCAs, staff working alongside HCAs, experts in relevant fields, and learning theory.

- 5 *Older People's Shoes* was received positively by trainers and HCA learners and appears to meet a need, particularly for established HCAs, that is not met in other training provided by employing Trusts.
- 6 The estimated per patient cost of an HCA receiving training in *Older People's Shoes* training is relatively small (£10.00-£20.00) when considering the average cost of a hospital stay for patients from this population (approximately £2000).
- 7 Drawing on lessons from the present study, we propose that a definitive cluster-randomised controlled trial of *Older People's Shoes* would be viable if the following methodological and contextual aspects were addressed:
 - While the focus on HCAs was considered a strength, greater awareness of this HCA- targeted intervention among ward managers and other ward staff members will re- enforce messages about relational care in the work place following intervention delivery. Ward manager involvement should extend beyond permission for ward participation.
 - Greater involvement of ward managers is likely to improve recruitment. Ward and patient level outcomes are only relevant if a high proportion (>80%) of the HCAs within each ward are recruited and 'treated as intended' within the trial.
 - Greater commitment and recruitment may be secured with a 'wait list' design whereby all wards (and HCAs) recruited are confident of ultimately receiving the intervention.
 - Ward managers need to be confident that they can secure backfill for staff to be released for training. While Trusts supported the CHAT study, it was not always clear how funds agreed for backfill could be secured by ward managers.
 - HCAs are willing to participate but are reluctant to complete questionnaires at three time points. The AGED Inventory appears to be a discriminatory measure but completion is sub-optimal.
 - More extensive training is needed for observers using QUIS. Where discrepancies occur between paired observers, this is typically when (and whether) one interaction ends and another begins rather than in the rating of the quality of the interaction.
 - The use of Trust-based research nurses to recruit patients has the advantage of impartiality, as they are separate from both the research and ward teams. However the additional layer this creates in communicating with an already hard to access population needs to be addressed.
 - Patients are willing to participate but questionnaire completion is burdensome. Methods of completion used by other studies to secure patient questionnaire completion (for example prior to discharge, using interviewers and/or proxies) need to be explored.