Research into social care workers undertaking healthcare interventions

FEBRUARY 2022

Skills for Care

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inspectors. Encouragingly, there is work underway to put in place greater standardisation in some areas.

8. published guidelines on delegation do exist (Appendix A includes a summary), but tend not to be holistic or applicable to all settings. Providers are therefore designing their own delegation standards and protocols, which risks further fragmentation of practice and oversight.

9. there is a shared agreement on the importance of training and monitoring in the context of effective delegation, but real-world experiences are mixed. Consultees cite pressures within the adult social care sector, including capacity issues relating to workforce development, as constraining factors on the quality and timeliness of training. Similar concerns were raised over ongoing monitoring supervision.

10. Other issues and challenges impacting on effective delegation were said to include funding, insurance and communication between health and social care partners.

11. Consultees cited the following key factors as being central to effective delegation:

- Buy-in from staff to whom the tasks are being delegated.
- Buy-in from individuals receiving care and their families.
- Clear and standardised governance, policies and frameworks.
- Collaborative, integrated working.
- Clear and open communication.

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Prevention e.g., theory and practice around fall and pressure wound prevention.

2.6 Consultees consistently reported that delegation was becoming more prevalent, driven in part by the pandemic and the need for providers to take on additional responsibilities. Interviews with CQC, LAs and CCGs supported this, with all of them reporting an increase in delegation-related enquiries and requests for information.

2.7 To provide guidance and a framework for employees to work within, several of the providers consulted had adopted a traffic light system for delegation, whereby tasks are placed into three categories:

standard care that can be undertaken by care workers that have completed mandatory training.

requires additional training and competency sign-off from a registered practitioner.

exceeds the level of care the provider is safely able to offer.

2.8 However, providers also noted that the distinctions between the above categories were becoming increasingly blurred. They spoke of a "needs must" situation under Covid-19, whereby they were routinely delivering elements of care that would normally fall outside of their remit. As discussed further in Chapters 3 and 4, some providers evidently feel that there are questions over the adequacy of the support, training and monitoring that they have received from registered professionals.

2.9 The majority of consultees agree that there is a strong

has been difficult to establish and maintain contact with their clinical leads and/or LAs and CCGs to discuss issues, concerns or risks.

3.6 This is also creating

The All Wales Medicines Strategy Group (AWMSG) advises the Welsh Government on the use, management and prescribing of medicines in Wales.

Currently, the AWMSG is working to address the lack of consistency in medicine policy and medicine support across Wales. Specifically, it is seeking to define key terminology as an initial step toward greater standardisation across health board authorities, the aim being to improve clinical governance and accountability.

Under the Wales Social Wellbeing Act, medicine management is commissioned and funded as a healthcare intervention. However, there is growing support for redefining it as personal healthcare and part of daily living, placing it within the remit of personal and social care.

Until the legislation offers clear guidance, the situation remains ambiguous and discussions about the clinical accountability and governance of medication management are likely to continue. The AWMSG is working alongside the National Commissioning Body to drive forward the delegation agenda.

3.18 Safety, clinical oversight and clear governance were said to be paramount for delegation to operate effectively. However, consultees also noted that managing delegation and taking on the responsibility for signing-off and monitoring responsibilities can introduce additional risk for registered clinicians and that some may be averse to this. Similarly, care providers themselves need to be risk-averse, which can result in a reluctance to take out delegated tasks without appropriate clinical supervision.

3.19 Several stakeholders also highlighted challenges associated with interpretation. Staff can be trained to undertake specific tasks, execute and monitor interventions and record information related to that activity. However, how that information is then used is also essential in ensuring quality of care and safety. In other words, staff may know how to record data but there is a greater level of risk if they lack a sound understanding of when that data requires them to take (urgent) action or escalate. In other words, performing a delegated task is only one part of the responsibility; accurate interpretation is equally important.

3.20 Lack of information sharing across different organisations and resistance to adapting practice were believed to be included among the consequences of inconsistent systems, blurred lines of responsibility and conflicting policies and approaches. There is a perceptible degree of frustration around delegation, often resulting from a perceived lack of understanding of each other's positions across and within the health and social care systems and between clinical, residential home, nursing home and home care settings. This can subsequently lead to limited coordination and planning and with individuals needing to negotiate and communicate with multiple organisations.

3.21 One stakeholder suggested that the process of delegation in general needs examining. Particularly when transitioning from a clinical to community environment and working

3.25 Consultees describe the funding structures around nursing, residential and home care as very variable, with delegation adding another layer of complexity. In particular, there is evident scepticism about whether the move towards greater delegation is driven by the positive impacts it can generate for people supported and

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4.1

Diabetes UK, the NHS and other stakeholders developed a voluntary framework to support the expanded capacity of insulin administration through community teams.

The Delegation of Insulin Administration Programme seeks to put in place a structured and safe mechanism for health and care staff, who are not registered nurses, to take delegated responsibility for administering insulin to adults receiving care in the community.

[redacted]

are based on best practice, input from stakeholders and an expert working group, together with the experience of eight national exemplar sites that have successful rolled out insulin administration programmes (Shropshire, Tameside and Glossop, Hertfordshire, Sirona Care and Health, North Tees and Hartlepool, Sheffield Teaching Hospitals, Barnet, Enfield and Haringey, and East Kent Hospitals University Foundation Trust). The materials include a comprehensive competency frameworks, management and employee checklists, a sample policy document FAQs and tip sheets.

[redacted]

ne framework, East Sussex Healthcare NHS Trust had
f insulin delegation in care homes and district nursing.
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4.3 In 2019, health and social care partners in Greater Manchester set up the Blended Roles Trailblazer to explore innovative solutions to system-

4.11 Consultees agreed that for delegation to operate with maximum effectiveness, efficiency and safety, it needs to be sustainable and supported by structures that are embedded within integrated health and social care systems. Rather than being treated as part of 'a project', it should be treated as a component of ongoing quality and service improvement.

4.12 Consultees were also pleased that Skills for Care had chosen to take stock of delegation within their sector and to hear from those involved about the opportunities and challenges it presents.

delegation and the knowledge and skills of the care worker to whom the tasks have been delegated.

5.1 The primary focus of the Health and Social Care Act 2008 was to create a new regulator (the CQC) whose purpose was to provide registration and inspection of health and adult social care services together for the first time, with the aim of ensuring safety and quality of care for service users.

5.2 Regulation 18 of the Act deals specifically with staffing issues to ensure providers

5.11 The framework is not specifically intended to cover issues relating to agency carers or other support workers, although many of the principles could be applied to them. It was informed by work carried out in NHS organisations between 2014 and 2016, supported by Skills for Health.

5.12 The framework urges CCGs to put in place clinical governance frameworks to regulate delegation, with clear guidance as to which tasks can and can't be delegated, how training and assessment of competence will be provided, and how clinical reviews of patients'

Only delegate tasks and duties that are within the other person's scope of competence.

Ensure that everyone they delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care.

Confirm that the outcome of any task they have delegated meets the required standard.

5.17 https://www.nmc.org.uk/globalassets/sitedocuments/nmc-

approaches to the delivery of care, and thus the following guidance has been issued by the AWMSG:

> The registered nurse is accountable for ensuring that medicines support is appropriately delegated to competent care support workers who have completed appropriate training.
>
> They should only delegate tasks and duties that are within the care worker's scope of competence.
>
> They should ensure the delegatee is adequately supervised.
>
> The care support worker should not provide any support with medicines unless this task has been delegated to them and the patient has undergone a needs and risk assessment.
>
> Care organisations should ensure that care support workers have access to the appropriate accredited education to support individuals with their medicines whilst not under the direct supervision of a registered nurse.
>
> The organisation will accept responsibility for all tasks undertaken by the care support worker, providing they are competently trained and are compliant with the agreed local written policies and procedures.
>
> The delegating organisation has vicarious liability for its employees.
>
> Care support workers must have completed one of the identified specific education units at Credit and Qualifications Framework for Wales Level 3 as a minimum or be able to demonstrate training to the equivalent.
>
> Additionally, an appropriate recognised accredited unit of learning in relation to supporting individuals with medication must be achieved.

5.23 https://awmsg.nhs.wales/files/guidelines-and-pils/all-wales-guidance-for-health-boards-trusts-and-social-care-in-respect-of-medicines-and-care-support-workers-pdf/

5.24 The Jersey Care Commission (JOC) is an independent, regulatory body which inspects care services provided by the Government of Jersey. The services they regulate include care homes providing nursing and personal care or personal support for people with a range of health and social care needs, care provided to people in their own homes, adult day care services and residential and other services for children and young people.

5.25 In 2019, the JOC released the Personal Care and Clinical Tasks Guidance for Adult Social Care, which was published to promote best practice across adult social care and to ensure that all relevant stakeholders are aware of their responsibilities when arranging, managing, delegating or providing care. It applies to individuals and organisations who arrange or provide care to adults receiving care from services which are registered under the Regulation of Care (Regulated Activities) (Jersey) Law 2018.

This includes homecare services, day care services, care home services and registered care/support workers who are self-employed or employed directly by individuals.

5.26 It includes a section titled 'Delegatable Tasks' which outlines nursing tasks, which in appropriate circumstances can be delegated to care/support workers. It also includes a list of tasks that are not acceptable for delegation. According to this guideline, the following tasks can be delegated, provided suitable training and assessment has taken place:

Capillary blood test.

Contraceptive devices.

Gastrostomy/jejunostomy Care.

Administration of certain medicines.

Non-invasive ventilation.

Temperature recording.

Obtaining urine samples.

5.27 https://carecommission.je/wp-content/uploads/2019/03/JCC-Guidance-personal-care-and-clinical-tasks-adult-social-care-ratified-20190314.pdf

A review of the literature to identify best practice in delegation was completed. This included scrutiny of the regulatory codes of conduct and practice. The analysis of the information revealed useful resources which have been used to support the development of these guidelines.

The involvement of clinical and managerial staff was essential to inform and influence the content and structure of these guidelines. Staff representing clinicians, trade unions, professional organisations and the education sector participated in the consultation. The representatives were asked to consider, amend, challenge and identify gaps in the draft guidelines. The information from the consultation process was collated and themed to reflect a consensus view on each of the guidelines. The guidelines were subsequently revised in response to the information received. The views of the individuals who attended the two consultation events was further sought on the revised guidelines for final validation.

Legal Advice was sought on the issues arising from the process of delegation and the associated implications. In particular, legal advice was provided on the principles of accountability for delegation and on the consequential issues such as vicarious liability.

Advice was sought from Professional Regulators and incorporated.

5.30 http://www.wales.nhs.uk/sitesplus/documents/829/all%20wales%20guidelines%20for%20delegation.pdf

5.31 https://heiw.nhs.wales/files/weds-practicing-appropriate-delegation/all-wales-guidelines-for-delegation-2020/

6.1 A new model to allow for the delegation of appropriate healthcare tasks and enable faster response times was piloted in Oxfordshire for an eight-week period in 2017. Participants in this pilot were two homecare providers on the Oxfordshire County Council approved provider list and the Oxford Health NHS Foundation Trust. The objective of the pilot was to increase capacity by integrating clinical and care delivery.

6.2 A care protocol allowing the Oxford CCG to delegate a certain set of responsibilities to paid carers under a formal and structured process was put in place. Healthcare tasks were risk assessed and separated into different categories depending on the level of training required.

6.3 The first category included warfarin administration, compression hosiery, TED stocking application and inhaler administration. These tasks were classed as Level 1 Portable Tasks. Carers who became proficient in them received a Portable Skills Passport, meaning they could deliver these tasks in the community. Tasks in the other categories

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7.1 Clear entry criteria for trainees required and compliancy with the mandatory training required by their employer organisations.

7.2 The registered nurse/registered practitioner must ask the healthcare worker (HCW) to confirm that they are willing to perform the task following training and with ongoing monitoring and supervision.

7.3 All modules of the training need to be completed and the task may only be delegated once competency is signed off by an experienced registered nurse/registered practitioner who will then act as a mentor.

7.4 The registered nurse/registered practitioner is accountable for ensuring that the HCW to whom they are delegating an insulin administration task is competent, based on their professional judgement and supported by the framework of e-learning and supervision which accompanies the policy. They must therefore ensure the delegated HCW is trained and has been assessed as competent.

7.5 It is vital that the register nurse/registered practitioner make sure the HCW has the ability to access advice and guidance from them on a regular basis (e.g. monthly clinical supervision and regular huddles to discuss cases) as part of a mentoring relationship - and the ability to access ad-hoc advice when needed so they can provide safe and compassionate care.

7.6 Competence should be reviewed on a six-monthly basis, or in response to any incidents occurring and/or being reported. If there has been break in practice for more than three months, refreshed training and updated competency assessment is required before the delegation of duties can recommence.

7.7 The competency assessment should be completed five times as part of the initial training and then once at six-monthly intervals by the registered nurse/practitioner.

7.8 A signed confirmation or verification of training (including e-learning) and competence assessment by the registered nurse/registered practitioner must be obtained from the HCW as assurance that the training and assessment of competence was successfully completed.

7.9 The HCW should have access to advice and guidance on a regular basis (e.g. monthly clinical supervision and regular huddles to discuss diabetes cases) as part of a mentoring relationship, and the ability to access ad hoc advice when needed.

7.10 Registers must be maintained to record the following:

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Records of e-learning completion, competency assessment, completion of checklist and final sign-off, held in the care homes' training records.

Annual review of registers undertaken by care homes through self-declaration and audited through random selection by the care home and Community Nursing.