Scottish Social Care Nurses' Journal

February 2025 Edition 6

Introduction to the sixth edition of the Scottish Social Care Nurses Journal.

Welcome to the Sixth Edition of the Scottish Social Care Nurses' Journal. As a network of dedicated professionals, we are committed to fostering inclusivity among all Nurses working in social care. We extend a warm invitation to Nurses from across the four nations and beyond to share their insights and experiences by submitting articles to our journal. In this edition, we are pleased to feature contributions from nurses working in social care in both England and Scotland. Additionally, we have an enlightening Op-Ed by George Coxon, offering his perspective on "What good looks like" in the realm of social care.

Our journal also highlights the development of Social Care Nursing Advisory Councils (SCNACs) in England, which aim to ensure '*stronger collaboration between other sector colleagues from workforce, research and HEIs.... making sure social care nursing and the wider workforce are included in the development of nursing plans...*' (Sturdy). Information has been provided by the Outstanding Society (www.outstandingsociety.co.uk), while these are based in England I had the opportunity to attend one of the meetings and perhaps consideration should be given to setting up a similar model in Scotland. Furthermore, I had the privilege of meeting with Professor Claire Pryor this month. Professor Claire Pryor is the first RCN Foundation Chair in Adult Social Care Nursing for the UK which is based at the University of Salford. Professor Pryor said on being appointed

'I *am excited and passionate about the new role, and the significant impact the focus on adult social care will bring. There is an absolute need to ensure our nurses working in social care settings are recognised, supported, and developed throughout their careers. We need to work toward recognition of social care nurses as a highly skilled, autonomous clinicians, and empower them to use specialist and advanced skills, leading and shaping high quality care across the sector.*' (Pryor, Nursing in Practice).

The new role was developed following a survey which was undertaken by the RCN Foundation and will take a '*strategic lead in shaping research and education in adult social care nursing at a local, national and international level*', (Ford, 2024).

Together we can change the narrative

The new post is a great opportunity which will help to raise the profile of nursing in Social Care, which is welcomed.

Dr Jane Douglas RN QN
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Editor in Chief

References

Ford.M. (2024) First RCN Foundation adult social care nursing chair appointed. Nursing in Practice, 365. https://www.nursinginpractice.com/latest-new/first-rcn-foundation-adult-social-care-nursing-chair-appointed. Accessed 26 January 2025

Pryor Claire.(2024) *School of Health and Society, News, University of Salford.* https://www.salfrod.ac.uk/news. Accessed 26 January 2025.

Sturdy, D. *Social Care Nursing Advisory Council.* https://www.theoutstandingsociety.co.uk/scnac/

Scottish Social Care Nursing Vision

'To create a fully inclusive network that represents the needs and outcomes of nurses who work in Social Care. Where the role of nursing in Social Care is recognised, supported and celebrated'

Purpose of the Network

- **To promote nursing in Social Care**
- **To provide a safe place to support nurses in Social Care**
- **To provide a safe place for discussion and debate**
- **To assist with professional role modelling and peer support**
- **To share good practice and develop quality improvement collaboration**
- **To review and suggest educational resources to support nurse in Social Care**
- **To contribute to consultations that impact on nursing within the sector**
- **To influence policy development and implementation**
- **To initiate and develop ideas for funding to assist with the development of Social Care Nurses**
- **To promote opportunities for the voice of Social Care Nurses to be heard.**

Op Ed - Opinion - written by George Coxon
What does good look like in social care?

The question of what good looks like has been asked in many settings over a great many years and I suspect I'm not alone in reacting ungenerously with a grimace and a wince. Let me example my difficulty with the premise. Firstly, I'd argue it's the wrong question isn't it? I'd suggest how does good FEEL is a far better route to address the inherently subjective and personal theme of quality in social care.Things can look great but when subjected to the reality of first hand experience it can feel dreadful.

I was thrilled to be asked again to respond to this so often asked question a little over a year after having been asked to write for Scottish Care and a few months after speaking at a truly exceptional Scottish Care Conference in Glasgow 2022.

Given the importance of the question, whether look like or feel like, I do have some thoughts to share and ideally stir and stimulate a response from others.

The piece I wrote for Scottish Care in a previous bulletin was tilted 'The Holy Trinity of Care Homes – Leadership, Culture and Language' (Coxon, 2023) so for me aspiring to be at least good must be embedded in these 3 essential elements – let me expand.

The importance of attributing what we do in our pursuit of good to the greatness of others – ie learning and emulating the best and giving credit to the inspiration we seek and find...

Leadership

Credible visible leadership is pivotal to ensuring a service looks and feels good. I've said throughout the 18 years I owned care homes in Devon that if a leader doesn't lead by example showing people how to do the work not just telling them then they are simply talking the talk rather than walking the walk, to coin a phrase. Being an active role model instilling the values and care practices that can be regarded as of a high standard is critical to good, even great care. So much of what is described as leading takes place 'off the pitch' and therein lies one of the most difficult aspects of leading with 'skin in the game'.

Perhaps leaders must make sure the proportion of time in the office is no greater than time with the' jobbing' care staff and also spent with those on the receiving end of care and support.

Culture

That old adage 'culture eats strategy for breakfast' certainly applies to good too. Culture undoubtedly eats good from breakfast as it does with kindness, enthusiasm, fresh ideas, curiosity, atmosphere and fun – all vital components in my book to addressing what good looks and feels like.

How to 'bake in' a culture that is both confident and humble, reflective and receptive as well as evidence informed and intuitive. All of these require the right mix of time taken to genuine openness to change and learning. A lesson I learnt late in my long and colourful multiple clinical, managerial, policy lead work and commissioning roles in the NHS was the importance of attributing what we do in our pursuit of good to the greatness of others – ie learning and emulating the best and giving credit to the inspiration we seek and find.

Language

How we speak about our work epitomises who we are and what we believe in and this in turn has the capacity to convey our values and beliefs to others. In social care we must be cautious about the risk of using institutionalising or infantilising language. Bad habits in how describe care can and does get handed on to all that join us – we learn quickly too, dare I say, patronising disrespectful descriptions of people we look after. Terms of endearment are meant well but sometimes are badly judged and can cause upset, disempowerment and offence, so be mindful of referring to people as 'dear', 'darling', 'my love' or 'pet'- check before you embark upon a road that can be perilous.The golden rule in terms of what good language looks like needs to be don't assume, ask and check.

Another contentious position I take regarding what good language in social care is that of the ubiquitous medical model and its pernicious impact and sometimes damaging manner it impacts of social care. Yes the medical jargon is often used without question, -diagnosis, disease, illness, treatment, symptoms and medication orientated language is important and we must have a better than adequate grasp on all it involves but these words disable and disempower.

I am more and more a sceptic when hearing the words 'person centred care' for which we have all been heavily immersed in and say often, this expression is never used by people we support or their loved ones and sadly is often weaponised by critical onlookers spoken in a questioning and accusatory manner! I am much more a believer and advocate for relational care or relationship focused care is what distinguishes care work from NHS based work.

I'm a promoter of the whole persons wants and needs – what matters, not what's the matter and have long spoken of happiness and fun being the feature part of care home life more so than illness and clinical interventions. As a final point can I offer one of my testing principles when I'm asked to peer review care homes – 'what do you call it when a new resident moves in?' I'm often hearing these days the reply not using the word 'admission' which pleases me no end, people move in or they arrive for a new chapter in a long and amazing life for those who need 24/7 care – care homes are not hospitals! I recognise nursing homes may have a greater challenge in combining health care demands with cheerful and quirky living but I know many nursing homes getting this balance marvellously right.

Having revisited the sentiments of my past writing and presenting for Scottish Care I'd like to add some further and final thoughts of what good looks and feels like if I may.

Rogerian Ethos

Having worked for many years as a Mental Health Nurse, counsellor and training psychotherapist prior to my NHS to care home migration I have been hugely influenced by the work of Carl Rogers, the American sociologist and leading figure in applying humanist theory to a health and care model of practice that promotes a set of essential characteristics for what good looks like in terms of relationships with others, these include:

- Taking the position that people are basically good
- Believing that even those who have made bad decisions or been unlucky in life, have the capacity to change in positive ways
- Empathy being about understanding not condemning or judging bad behaviour and seeking ways to empower positive choices and control for the person
- Seeing unconditional positive regard and belief in the power of support without directiveness as central to growth
- Non possessive warmth enabling care to be offered without taking responsibility for change away from the person

Rogers was the founding father of non directive counselling and person centred care with many believing it to be a vital inspiration to help us achieve great care.

The '4 ships' of what good looks like

I've mentioned already the importance of leadership being key to achieving good care but as described in the must watch 3 minute TED talk by Derek Sivers-how to start a movement – (Sivers, 2010), leadership requires followership that often requires the ability to enthuse, ignite and inspire others to emulate the values of the leader [NB please do watch the 3 minute TED talk – you won't regret it!].

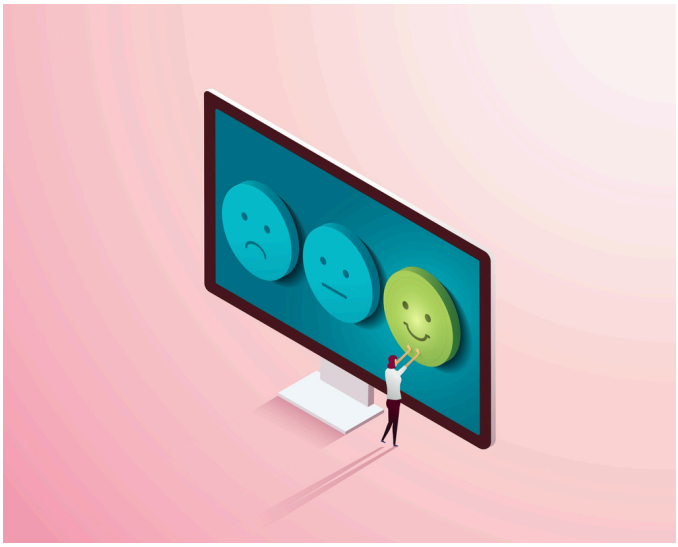
A third 'ship' and again pivotal to good care is unsurprisingly partnership with others most particularly the person being cared for and their loved ones but equally partners in care including all stakeholders such as health care professionals, advocates, and anyone with a part to play in ensuring the health and wellbeing of any of us.

A 4th and perhaps most critical 'ship' of my suggested ships is the relationship which we develop with those we are helping, supporting and caring for. Like partnerships, they relate to how we interact and sustain a good set of authentic trusted and trusting connectivity with those we aim to help.

'what do you call it when a new resident moves in?' I'm often hearing these days the reply not using the word 'admission' which pleases me no end, people move in or they arrive for a new chapter in a long and amazing life for those who need 24/7 care – care homes are not hospitals!

Likeminded alliances

Not so long ago several of us across the border north and south established what we referred to as the Anglo Scottish Care Alliance where we met online – mostly in and around the Covid pandemic, sharing treasures and exchanging ideas and experiences based on a common bond and mutual admiration and respect. Seeking and finding likeminded allies including during difficult times is another indicator of what good looks and feels like. We should all do this if we don't already – peer support helping receptive learning and adapting great care from those doing different things to current practice is further evidence of good.



Putting it all to the test

My last thoughts on what good looks and feels like must of course be how we put all of what we do to the test. Inspections, regulation and benchmarking key performance targets might be part of this but despite many of us I fear trotting out the expression 'if it isn't written down it didn't happen' and the critical value placed on documentation and recording good care it must be conceded the opposite is also true – 'just because its written down didn't mean it happened!'

It's said the omission we disregard or the standard we ignore is the standard we accept so what good looks like needs to have scrutiny or continuing quality considerations embedded in our work. Encouraging pride and a desire to get it right first time (GIRFT) and every time is both a personal driver as well as a team fundamental principle. One of my many care mantras developed over my long and hugely adrenalin fuelled health and care career has been that the work in social care is like the work of a garden – it's never finished but in each part, is fanatically rewarding and life enhancing filled with joy, love and hilarious moments. Seeing these in practice, for me, is surely what good looks and feels like.

References

Sivers, D. (2010). How to start a movement. TED http://www.ted.com

Coxon, G. (2023). Culture, Language and Leadership - the Holy Trinity of Care Home Life. *Scottish Social Care Nurses' Journal*, Edition 3 April 2023, 4-5. https://www.scottishcare.org

George Coxon RMN
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This edition's blog has been written by Lauren Jones

A day in the life of a Complex Care Dementia Nurse

Firstly let me introduce myself. My name is Lauren I have been qualified as a nurse now for nine years, although I have worked in social care for the past 13 years. I started as a carer in a residential home but have worked as a qualified nurse since 2015. I currently work in the West Midlands.

There is something about spending time one to one and helping and assisting people with their meal and seeing them get enjoyment from it, that is just heart warming!

I usually arrive on shift at around 07-40 am. Put my bags away in the office, grab my coffee cup, my notebook a pen and head to the dining room for handover.

The unit is a hustle of activity.
Our residents are usually up and about walking with purpose in the corridors, in and out of communal areas.

Laughter can usually be heard from the server as staff catch up with each other, night staff greet day staff and people are chatting about recent events.

With my coffee in hand I sit and take the handover until around 8am where I then delegate my staff for the day, go through the diary and make a plan – which we usually never get to stick too due to the unpredictability of the unit.

One thing I learnt pretty quickly is don't assume that anything will go to plan in dementia care. It's one of the things I actually most love about the job – every day is a challenge, constant thinking outside of the box.

Once allocation is complete is morning medication round and breakfasts. The morning up until half 10 is usually quite intense. If this part of my day doesn't go well it really can affect the rest of your day.
The next hour and a half is usually admin time.

Recording the medication round, beginning my diary jobs, organizing meetings, reporting for GP rounds. Documenting anything considered significant in my daily notes and before you know it it's already 12pm!

Next medication round is due – I like to base myself in the dining room for this round.

It's a hive of activity – with domestics, kitchen staff and meals from the hatch, but such a lovely atmosphere. I like to try and administer my 12pm medication to my few residents and then I try to assist at least one resident with their meal over this time. I find it special. So much of my morning is taken with administrative tasks that its nice to just take a moment to have one on one time. It's the reason I came into nursing after all, not to sit at a computer but to care for people.

Being a Registered Nurse on the unit isn't just task based. The above is the bare necessities. The real reason I love my working in complex care is of course the residents.

I always finish my shift with thanking my staff on shift for the work that day.

There is something about spending time one to one and helping and assisting people with their meal and seeing them get enjoyment from it, that is just heart warming!
After lunch it is usually time for my GP round and further documentation.

I also use this time to complete any dressings which I have on my list that day and to complete any further assessments and update my care plans.

The afternoon is when I usually try to grab my lunch and take a short break from the busyness of the day.

There is also another handover at 2pm for staff whom are joining us for the late shift.
The afternoon the unit is usually the time we get the most visitors – the unit can be loud and bustling but it is lovely to see our residents being visited by loved ones.

4 pm – You guessed it! – A further medication round.There is only a few at 4pm and my medication round at around 5pm. There is quite a few the residents living with Parkinsons Disease on the unit so timely medication can often dictate your day, at times this can be a challenge but can also provide good structure.

Post medication it is then just more documentation. Ensuring my shift is wrapped up.

Spending time having a debrief with my care staff ensuring that any of there concerns for the day have been reported and answered.

All my tasks for the day have been completed. Everything is documented.
My handover document is completed ready for the shift changeover at 8pm.

It's a hive of activity – with domestics, kitchen staff and meals from the hatch, but such a lovely atmosphere.

I always finish my shift with thanking my staff on shift for the work that day. Being thanked and feeling appreciated, in my opinion, really can make your team feel closer.

Being a Registered Nurse on the unit isn't just task based. The above is the bare necessities. The real reason I love my working in complex care is of course the residents. The daily challenge. Problem solving and being a detective in order to ensure we are providing the best possible care for them. I honestly couldn't imagine working in anything other than dementia care.

This blog was written by Lauren Jones BSc Nursing RMN

My name is Lauren Jones. I am busy working Mum of two small childrens who are six and three. I have been qualified as a Mental Health nurse for 9 and a half years. I studied at the University of Birmingham after growing up in the North West. I hold a passion for dementia nursing with a particular interest in complex care. I have worked in social care since I qualified and this is truly were my heart lies. I currently work in a large care home in the West Midlands where I work on a mixed complex care dementia unit. I hold a particular interest is the assessment of mental capacity and promoting the independence and choices of individuals living with dementia. I truly believe we have come such a long way in dementia care nursing but still have a little way to go. I truly can't see myself ever working in another area. I'm very lucky to love the area and field I work in and hope to continue this for a long time."

This second blog is written by Angela Penman, who is a Care Home Manager with Abbotsford Care in Scotland

I have been working at Abbotsford Newburgh for almost 4 years, building on my 16 years experience in care homes. Over the years I have developed a deep passion for providing compassionate care, particularly in the areas of palliative care, wound care and assessment processes.

One of the most fulfilling aspects of my role is the balance between technical knowledge and what I call that nurse gut instinct. There is something intuitive about understanding a Resident's needs beyond what is written on any charts. This may be noticing subtle changes in behaviour or acting quickly when something feels off. I Have learned to trust that blend of experience, knowledge and instinct to guide my decisions.

It's incredibly rewarding to see others discover new skills or gain confidence in their abilities, knowing I have played a small part in their journey.

Another passion is learning and development. I believe that growth is not just for oneself but it is something to be shared. This is why I have been dedicated to supporting my colleagues to access tools like the TURAS platform, empowering them to take responsibility for their own professional development. It is incredibly rewarding to see others discover new skills or gain confidence in their abilities, knowing I have played a small part in their journey.

We also support student nurses and student paramedics with their learning journey, providing them with a safe environment full of experiences, where they can apply their theoretical knowledge and gain confidence in practical experiences and build professional relationships with staff, residents and other health care professionals.

At the heart of everything I do is the belief that care is not just about tasks, its about connection, respect and creating an environment where residents and staff feel valued. Working at Abbotsford has allowed me to combine my clinical expertise, intuition, and passion for development into a role that's deeply meaningful. I look forward continuing this journey always striving to learn, grow and inspire those around me.

Supporting the Future of Health Care

Our care home actively participates in the training & development of future health care professionals by offering placements for Student Nurses where they gain practical experience in nursing care. Student Paramedics where they can apply theoretical knowledge in a real-world setting, practice their communication skills and learn about care home life. We also take school students who are exploring careers in health care. Voluntary access to nursing students where they are looking to build foundation skills for entry into the nursing profession.

These placements are mutually beneficial, providing students with hands-on experience while enriching the care home environment with fresh perspectives and enthusiasm.

The students are closely supervised by experienced staff, ensuring they receive guidance and feedback while maintaining high standards of care, we are able to offer this level of support by ensuring our staff are suitably trained for their roles, and ensuring they have access to continued professional development, we have utilised the TURAS platform where all staff have TURAS accounts with over 500 modules completed this far.

The care homes atmosphere changes as the students bring energy, curiosity and fresh ideas that positively impact the home.

There are many benefits to welcoming students into our home. The students acquire practical skills such as patient care, communication and teamwork. Building confidence working in a safe environment where they can learn and feel more prepared for future roles. Interpersonal growth as students learn from meaningful relationships with residents, fostering empathy and compassion. All students are tasked with carrying out an activity with the residents and / or carry out a presentation on what they have learned and this is shared with the relevant university.

The care homes atmosphere changes as the students bring energy, curiosity and fresh ideas that positively impact the home. The staff enjoy sharing their knowledge and experiences, which serves to strengthen team morale. The residents engage well with the students, as residents like speaking with the younger generation, creating a sense of connection and purpose.

The residents teach the students about life experiences and the value of compassionate care. Students are encouraged to become part of the care home team, building trust with residents and staff. The student placement programme at our care home plays a pivotal role in supporting the development of future nurses, paramedics, and other healthcare professionals.

At the same time, it enriches the care home environment by fostering meaningful relationships and creating opportunities for learning and growth. This initiative underscores our commitment to quality care and the importance of collaboration in building a compassionate and skilled healthcare workforce. We have moved from a traditional care model to one that is driven by continuous learning, self-improvement and innovation all of which we can share with all students who receive a placement within the home.

Angela Penman is the Care Home Manager at Tayside View

Make the only shot count: Palliative and end-of-life care in care homes an article by Ruth Ngomo, RN, BSc, MBA, Level 7 H&SC Management

Our role and responsibility as care workers in care homes includes providing support and guidance for quality care, including a good death. Normalising discussion on death and dying continues to be one of the biggest challenges in implementing palliative and end-of-life care in care homes. When palliative care is assessed and advanced care planning is discussed with the residents and their families, there is a guaranteed smooth transition from palliative care to end-of-life care. This enables the implementation of a person's end-of-life wishes and preferences.

The advance care plan captures the person's wishes for their future care. Implementation of these recommendations remains a challenge due to barriers such as poor advanced care planning training for health care workers and lack of confidence in discussing death.

The historic vote of the assisted dying bill in England and Wales is another opportunity and a wake-up call for us all to have these conversations at the appropriate time as we provide person-centred care. It remains the responsibility of care professionals to provide updated, unbiased information to residents and their families to make informed choices.

As we continue to reiterate reflective palliative and end-of-life practices in care homes, the timing could not have been better with the recent publication of The National Confidential Enquiry into Patient Outcome and Death; ' Planning for the End: A Review of the Quality of Care provided to adult patients towards the end of life'.

Although the integration of quality end-of-life care in the UK has seen a significant effort by the government and other alliances to improve the quality of life for people in palliative and end-of-life care, this report indicates there is still much to be done in the assessment and implementation of effective palliative and end-of-life care, the study established the benefit of timely palliative care planning for a seamless transition to person-centred end-of-life care, (The National Confidential Enquiry into Patient Outcome and Death, Planning for the end, 2024).

The National Institute for Health and Care Excellence (NICE) recommends a patient-centred care approach where patient and their families are involved in the decision-making regarding their care. The advance care plan captures the person's wishes for their future care. Implementation of these recommendations remains a challenge due to barriers such as poor advanced care planning training for health care workers and lack of confidence in discussing death. These results in ineffective patient-centred care, (The National Confidential Enquiry into Patient Outcome and Death, 2024).

Applying recommendations to care home setting

The study aimed to analyse the quality of care provided towards the end of life for adults with a diagnosis of dementia, heart failure, lung cancer, or liver disease was reviewed. The sampling period of death or final admission (for community deaths) was between 1st April 2022 and 30th September 2022

As care workers and educators of community members, we should drive this home as we intentionally practice effective and reflective care for our residents.

Finding	Recommendation
Death and dying were not discussed as often as it could have been. More people need to have their end-of-life care wishes recorded. 72.5% of patients did not have their preferences for care at the end of their life recorded	Communication was an area for improvement and good practice. This included how patients and their families were included in decisions about the care being provided and advanced care plans.
When a lead person was documented, specific end-of-life documentation was used in 162/243 (66.7%) patients, compared with 44/134 (32.8%) where there was no lead person documented (a common practice with oncology care)	Care home settings to adopt and appoint palliative care leads to facilitate discussion and documentation.
Training to identify when palliative or end-of-life care will help was not always provided or available.	Have tools to assess palliative care need, to establish who will benefit from palliative care and treatment.

Death is inevitable for everyone and at the very end of it we only have one chance to make it a good and right experience for the person and their loved ones. Communication, planning, and implementation are critical in this equation. It remains our duty of care to normalise death and dying discussion with empathy, to give everyone we care for the opportunity of a good death!

References

The National Confidential Enquiry into Patient Outcome and Death. 'Planning for the End' 2024. London (accessed 23.11.2024)

NICE National Institute for Health and Care Excellence (NICE) (2011 modified 2013). Quality standard for end-of-life care for adults. NICE Quality Standard 13. London: NICE. Available at: End of life care for adults (accessed 23.11.2024).

Ruth Ngomo is the Registered Manager for a nursing home with a turnaround portfolio in Bradford.

Kirsty Cartin RN QN is the Care Home Manager Rashilee, Littleinch Care Group,

Celebrating Care Every Day: The Journey to 'Care Service of the Year' at Rashielee Care Home

On November 15, 2024, Rashielee Care Home reached a significant milestone in its journey—a moment that will always stand as one of my proudest in a career devoted to care home services. That night, we were awarded 'Care Service of the Year' at the Scottish Care Awards, a recognition of the exceptional dedication and passion of our entire team.

For a long time, I hesitated to enter any awards. The idea felt self-indulgent—as if we were merely 'blowing our own trumpet.' The entry forms intimidated me; they demanded evidence I wasn't sure I could articulate or substantiate. Most importantly, I feared disappointing my staff if we didn't meet the criteria.

But things began to change. Slowly, I noticed growing recognition within the sector. Fellow professionals respected our innovative approaches, sought our staff's expertise, and shared powerful testimonials from residents and their families who recognized that we offered 'something different.' A wave of encouragement from our team also emerged—they wanted to showcase what made Rashielee special.

Applying for the award was a team effort from the start. We worked together to answer questions that highlighted how Rashielee met and exceeded the criteria. Residents, visitors, and staff provided invaluable testimonials. These heartfelt words became a source of pride for the team, validating their work and inspiring further excellence. Staff members suggested real-life examples to showcase our commitment to residents, our community, and each other. It truly takes a collective effort to win 'Care Service of the Year.'

I hesitated to enter any awards. The idea felt self-indulgent—as if we were merely 'blowing our own trumpet.'

The excitement was palpable when we learned we had been shortlisted. Plans for the awards ceremony at the Hilton in Glasgow began immediately. Determined to ensure broad representation, we invited staff from all departments, including those specifically mentioned in the application. Each invitee expressed deep gratitude and pride in representing their colleagues.

So, what sets Rashielee apart? At its heart, it's our focus on relationships—the foundation of everything we do. Our relationships with residents, families, staff, and professional partners drive our ability to deliver person-centred care. Strong bonds between management and staff enable personal and professional growth, fostering a supportive environment where potential is nurtured. We also prioritize community engagement, collaborating with local schools, churches, and organisations to ensure residents remain connected, valued, and included.

Our leadership team is passionate about influencing policy and transforming perceptions of care homes. We actively participate in research and regularly welcome student nurses for placements. Continuous improvement is at the core of our practice—we invite suggestions from anyone invested in Rashielee, holding a 'no fear' policy to innovation. Quality Assurance Cafés with the wider staff team ensure our understanding of audits, surveys and minutes of meetings meet correlate with those on the frontline.

Supporting staff is a top priority. Our low turnover rate is a testament to our positive work culture. Most vacancies result from retirement or educational pursuits. We believe that supported, valued staff will, in turn, provide compassionate, high-quality care.

Awards are one way to celebrate social care's vital role in enhancing lives, but recognition shouldn't be confined to once a year. Share success stories daily—on social media, with local media outlets—and speak openly about challenges. Honesty about our challenges opens up discussion and, in that discussion, we may find answers to our problems. By sharing initiatives and collaborating freely, we strengthen the sector together. Rashielee's journey reminds us all: celebrate, innovate, and elevate care every single day.

Kirsty Cartin RN QN

Littlelnch

Scottish Social Care Nurses' Journal

Reflections from The International Council of Nursing, NP/APN 13th Network Conference, Aberdeen, Scotland, UK

Kim Barron
Advanced Nurse Practitioner
Robyn Murray
Trainee Advanced Nurse Practitioner
Erskine Veterans Charity

As advanced nurse practitioners working exclusively and employed by a social care organisation we often feel like the 'odd ones out' in various professional arenas.

Being able to attend a conference at an International level opened our eyes to the multitude of ways health and social care systems function across the globe and left us feeling small but in the best possible way!

The conference offered us the ability to take a step back and take the time to reflect, something that although felt like a luxury also felt by the end to be a necessity. Being able to gain perspective and see nursing for the global profession it is showed us that the we belong to something bigger than NHS or Social care. It showed us that we are all facing the same difficulties and that we need to be creative and work synergistically to meet the challenges ahead.

Although at times it was easy to feel intimidated by the giants of nursing there, we were able to engage in dialogue with practitioners we would never have come face to face with otherwise and have hopefully opened some doors to cross continent work and learning.

The need for practice to be proactive was identified as core to the direction we all need to be moving in globally, as the cost of reactive care is only escalating, particularly as we are living longer and living under more stress.

It is fair to say we have left with more questions than answers to how we move forward but the quality of questions we are now asking has gained depth and are ultimately more innovative. Being able to understand the work of others who are doing things differently sparked more than one 'ok so why can't we do that too?' question and has led us to explore our own ways of working and question the ties that bind us.

The three big take home messages for us in relation to social care were the ideas and discussions around multi professional working and proactivity in care.

ERSKINE
Veterans Charity

The conference was specifically for advanced nurse practitioners or nurse practitioners are they are called in the USA and Canada but many of the discussions were around advanced practice overall and how as other professions develop their advanced practice we should be working and developing together. This need to work with other disciplines meaningfully regardless of level of practice is not new and has come into focus as more essential than ever in order for health and social care services to be able to meet the evolving needs of our populations.

The need for practice to be proactive was identified as core to the direction we all need to be moving in globally, as the cost of reactive care is only escalating, particularly as we are living longer and living under more stress. There was much discussion and debate about how challenging this is and the political climate inevitably influence the ability of good intentions coming to fruition.

As advanced nurse practitioners working exclusively and employed by a social care organisation we often feel like the 'odd ones out' in various professional arenas.

The four days were a sea of research projects and contributions to the body of nursing knowledge that continues to grow exponentially. From a UK perspective the voice of social care was not present which ignited a spark in both of us to contribute and we will explore further what that may look like.

As the conference left us with a plethora of questions we will leave you with some which might support your own reflections,
Why am I not fulfilling this role, where does it say I cannot?

- In what ways do I work proactively?
- Am I the barrier to proactive practice or is it part of the system I work in?
- How do I contribute to the body of knowledge in not only my own sphere but outwith?
- Can I engage further in audit and research and share this?

We would like to say a massive thank you to Dr Jenni Burton and to the Dunhill Medical Trust Academy https://dunhillmedical.org.uk/academy/) for supporting us to attend this conference. Without their support it would not have been possible for us to attend.

Social Care Nursing Advisory Councils (SCNACs) – Information Overview

Introduction

"*Social care nursing is an important part of the health and care system. The reforming of the Social Care Nurse Advisory Councils (SCNAC's) into 7 regional councils will ensure a stronger collaboration between other sector colleagues from workforce, research and HEI's and facilitate a greater number of voices to influence and shape work with NHSE ICB (Integrated Care Board) Nurse colleagues and their teams. These forums will act as touchstones for every ICB nurse, making sure social care nursing and the wider workforce are included in the development of nursing plans across all health and care settings. These peer advisory groups bring a wealth of experience, insight and expertise to the table, better informing the development of nursing practice, system wide. I hope colleagues will come forward and be part of that critical social care nursing specialist voice.*"
Professor Deborah Sturdy CBE

1**. Purpose**

The primary role of these councils is to provide information and guidance to the regions regarding Adult Social Care Nursing. They serve as a reference point or a reliable source of advice for matters related to Adult Social Care Nursing within their respective regions.

2. Aims and Responsibilities

·Our aim is to foster collaboration and partnership with ICBs, NHS, Social Care Providers, Local Authorities, and other stakeholders.

- We will engage with Chief Nursing Officers (CNOs) and Nursing Leads to advocate for the inclusion of Adult Social Care Nursing perspectives at strategic and operational levels.
- Define the two Adult Social Care priorities for the region, linking with both national and local considerations.
- Stakeholders to share learning, new ideas and celebrate best practices.
- To identify representatives to attend stakeholder meetings on behalf of the SCNACs and the Chief Nurse for Adult Social Care and feedback on the outcomes to the Council.
- Review progress, key risks and challenges relating to nursing in Adult Social Care
- ·dentify the priorities and champion best practice related to education and research within Adult Social Care.

Council Structure

SCNACs are regionally structured, with each council representing a specific geographic area. Each council is typically led by a Chair and Co-Chair who work collaboratively with council members to develop strategies and initiatives aimed at addressing local and national challenges in Adult Social Care.

Benefits of Involvement

By participating in SCNACs you can:

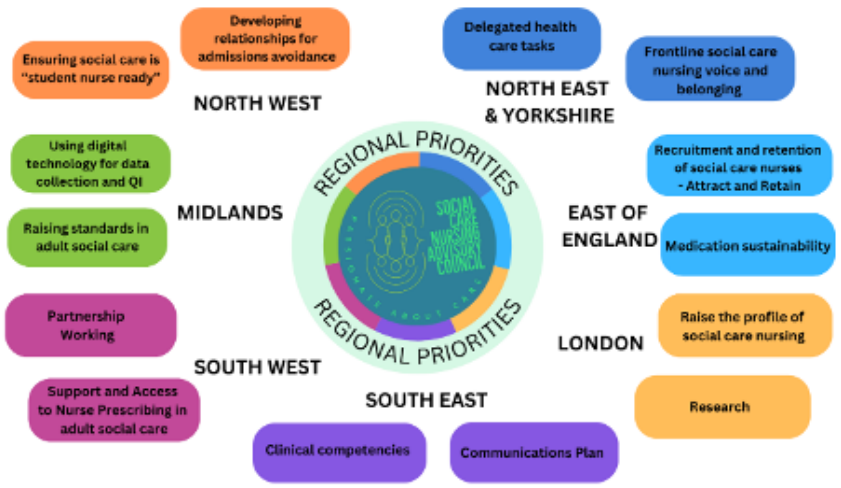
- Strengthen collaborative working across health and social care
- Contribute to shaping the future of Social Care nursing.
- Gain access to a strong professional network and leadership opportunities.
- Influence key decisions that affect the profession and those who rely on Social Care services.

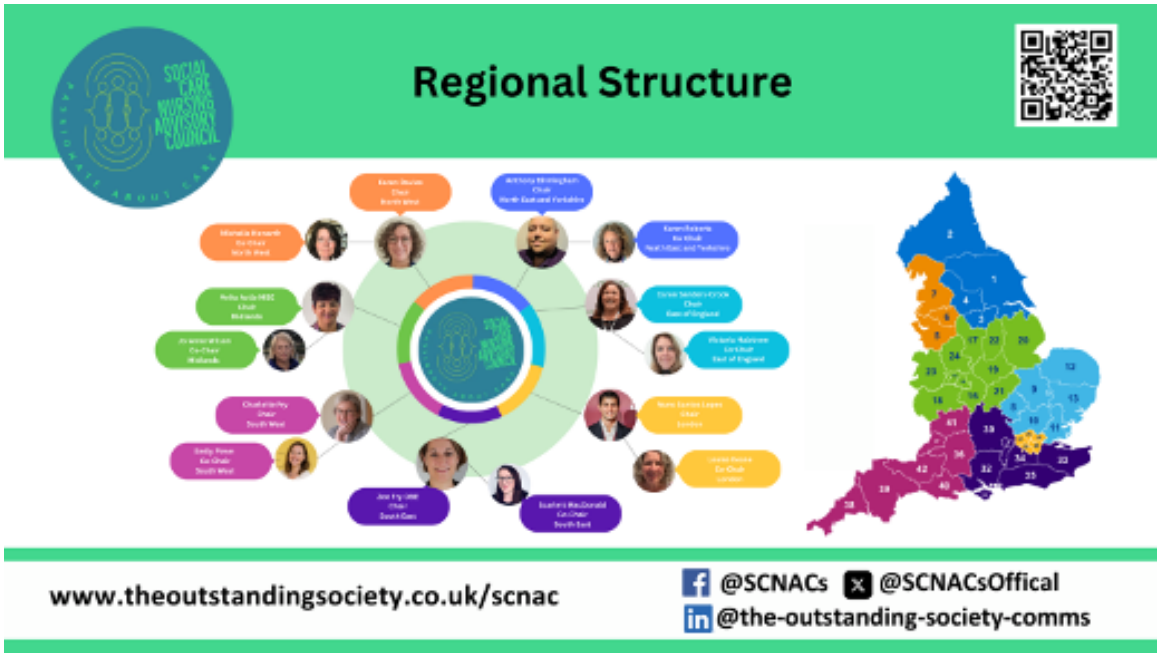
Contact Information

For more information on the SCNACs or to get involved, please contact Sonia at admin.scnac@theoutstandingsociety.co.uk or visit https://theoutstandingsociety.co.uk/scnac/

"Nursing is a significant part of the answer to delivering reform, and this event has set the tone for how, through those close relationships and strong leadership, we can make that happen."
Prof. Deborah Sturdy, CBE - Chief Nurse for Adult Social Care

"*As nurses, we know that collaborative working across Health and Social Care is key to helping us improve outcomes, care and experience for the populations and communities we look after.*
The work the Councils are doing in this space is not only helping to strengthen collaborative working across local systems, but across our nursing profession and Health and Social Care as a whole."
Duncan Burton, Chief Nursing Officer for England




Regional Structure
www.theoutstandingsociety.co.uk/scnac
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'While working as a Professional and Practice Development Nurse with NHS Tayside, I had the joy of meeting care homes teams to offer support with professional or practice development. Being unfamiliar with the role of a care home nurse, I was astonished by the range and breadth of work to manage. It came as no surprise to find excellent, person-centred nursing care being delivered, but I hadn't appreciated the levels of comprehensive, complex assessment and care planning which the role involves.

This was naïve; I had a notion specialist care for those living in care homes would be offered by specialists or other community services, but nurses working in the care home were delivering or managing much of it. Most of us working in nursing will have a particular focus or demographic but those looking after those in a residential setting have the job of enabling an individual to live a fulfilling and enriched life, and that is huge.

There is so much to consider from pressure area care, nutrition, rest, physical health, mental health, connections with family and friends, enabling participation in activities to end of life care. All considered and delivered in a bespoke and person-centred way, often in rapidly changing circumstances, and carried out with dedication and apparent ease. The nurses and health care professionals I spoke with knew those they cared for well; some said they felt like family. As a Nurse with a role for supporting others, I left this post with a realisation that I am the one who had most to learn. What role is more important than being trusted to ensure someone has everything they need to live a full and enjoyable life? Care home Nurses are highly skilled, great communicators and I suspect, often overlooked as a source of expertise and advice about how to deliver excellent person-centred care.'

Emma Legge QN RGN
Professional Nurse Lead (Leadership)
Queen's Nursing Institute Scotland

For more information about the Queen's Nursing Institute Scotland, visit their website - www.qnis.uk

If you are interesting in submitting an article for the Journal contact Jane Douglas -janedouglas@jedconsulting.co.uk and you can be issued with guidance to help support your submission.

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News & other information of interest

Stalpers, D, Schoonhaven, L, Dall'Ora, C, Ball, J, Griffiths, P. (2025)Entanglement of nursing care': A theoretical proposition to understand the complexity of nursing work and division of labour. I*nternational Journal of Nursing,* Volume 163, March 2025, 104995
https://doi.org/10.1016/j.ijnurstu.2025.104995

Appreciative Inquiry - here is a link to workshops that you maybe interested in:
https://bit.ly/AppreciativeInquiryWorkshops

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https://www.unsplash.com