Does the introduction of holistic care planning have an impact on the wellbeing of people with frailty?

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Background

The NHS Five Year Forward View [1] recommended more integrated working to help frail and older people stay healthy and independent reducing the number of emergency admissions, delayed discharges and readmissions.

Clinical guidelines recommend holistic, patient centred care planning as a means of reducing unplanned interventions. [2,3]

The initial aim for this project was the introduction of holistic care planning in a local community team. When serious concerns were raised about the safety of care within a local intermediate care setting the project was reframed around addressing these concerns as a matter of urgency.

Project aims

1. Introduce holistic care planning for patients under the care of community care teams
2. Increase staff knowledge and skills in frailty and care planning
3. Study the impact on the numbers of patients with care plans
4. Introduce multidisciplinary care planning and goal setting to patients in a local nursing home providing intermediate care
5. Study the impact of care planning in the nursing home

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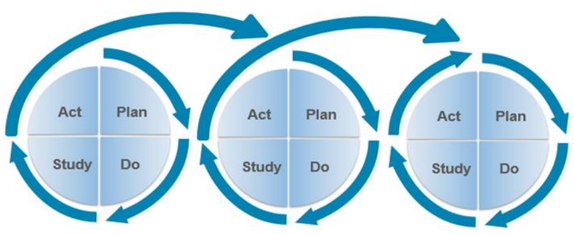
PDSA Model for Quality Improvement



PDSA Cycles 1-4

P Collect baseline data on numbers of patients with care plans and staff who have undergone training in frailty and care planning.
D Address training needs, support staff with care planning
S Repeat data collection, talk to patients and staff about their experiences
A Update training in light of the feedback

Results
Due to challenges in engaging staff it was not possible to deliver training within the time frame of the project, change in clinical priorities necessitated altering the focus of the project

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PDSA Cycle 5

Project reframed to address patient safety concerns in a local intermediate care facility.

Process mapping of the patient journey identified areas for improvement in safety and quality of rehabilitation.

P Introduce shared care planning, goal setting and discharge documentation
- Survey SHFT staff about patient care, eight statements, five point Likert scale (1= strongly agree, 5= strongly disagree)
- Patient interviews
- Audit against NICE Guideline on Intermediate Care

D New documentation designed and introduced at weekly MDT meeting ,
S Nurses and social worker unfamiliar with some ideas and requested training
A Meet registered manager to plan teaching session

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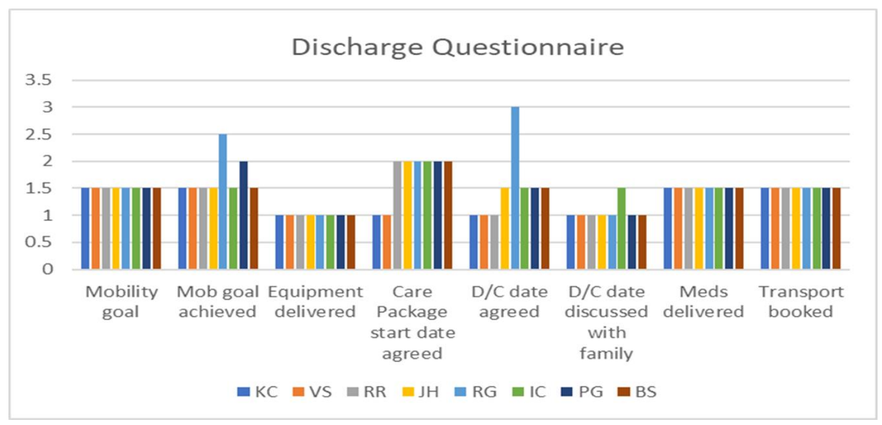
Results Cycle 5



- Questionnaire results and staff comments do not correlate except in case of RG
- Insufficient data to provide meaningful feedback
- Patient interview suggested positive experience but few insights into care planning experience

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References

[1] NHS England (2014) ***NHS Five Year Forward View***. Available from https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf [Accessed 08/11/2017]
[2] National Institute for Health and Care Excellence (2017) ***Intermediate care including reablement.*** Available from https://www.nice.org.uk/guidance/ng74 [Accessed 06/10/2017]
[3] British Geriatrics Society (2014) ***Fit for Frailty: consensus best practice guidance for the care of older people living in community and outpatient settings.*** Available from http://www.bgs.org.uk/campaigns/fff/fff_full.pdf [Accessed 07/11/2017]

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Discussion

- Challenges to staff to participation need to be examined fully in order to plan future work
- Clarification required around automated data collection policies
- Shared documentation and trusted assessments allow for safer, more efficient patient care, every effort should be made to ensure that governance structures support these practices when different providers work together to deliver intermediate care
- Shared processes could help to address cultural differences in practice