

Achieving outstanding end of life care in Care Homes

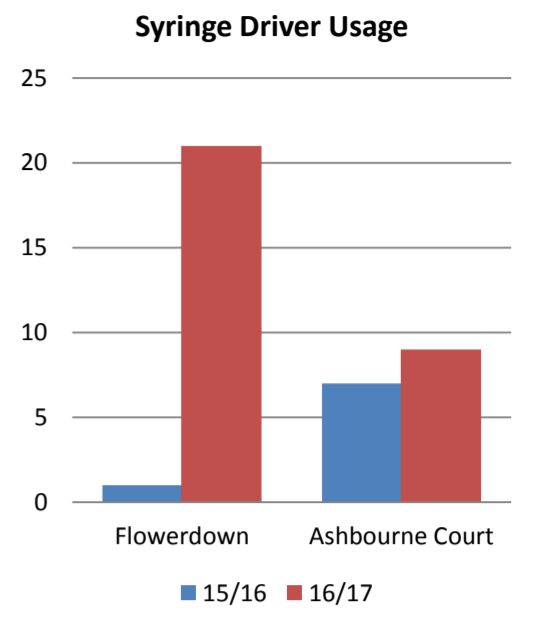
1.0 Background

Meeting individuals preferred place of care and death is essential in achieving outstanding end of life care. We recognise that the complex discharge process involving multiple agencies leads to delays in transfer of care. Those at the end of their life face profound physical and emotional changes and the impact on them and their loved ones cannot be underestimated. In 2017, 23% of people died in care homes (Public Health England) and this number is increasing: care homes are playing an important role in providing end of life care. Therefore, care home staff need to be equipped with the knowledge, skills and confidence to be able to pro-actively manage their symptoms and meet the emotional needs of their residents and their families.

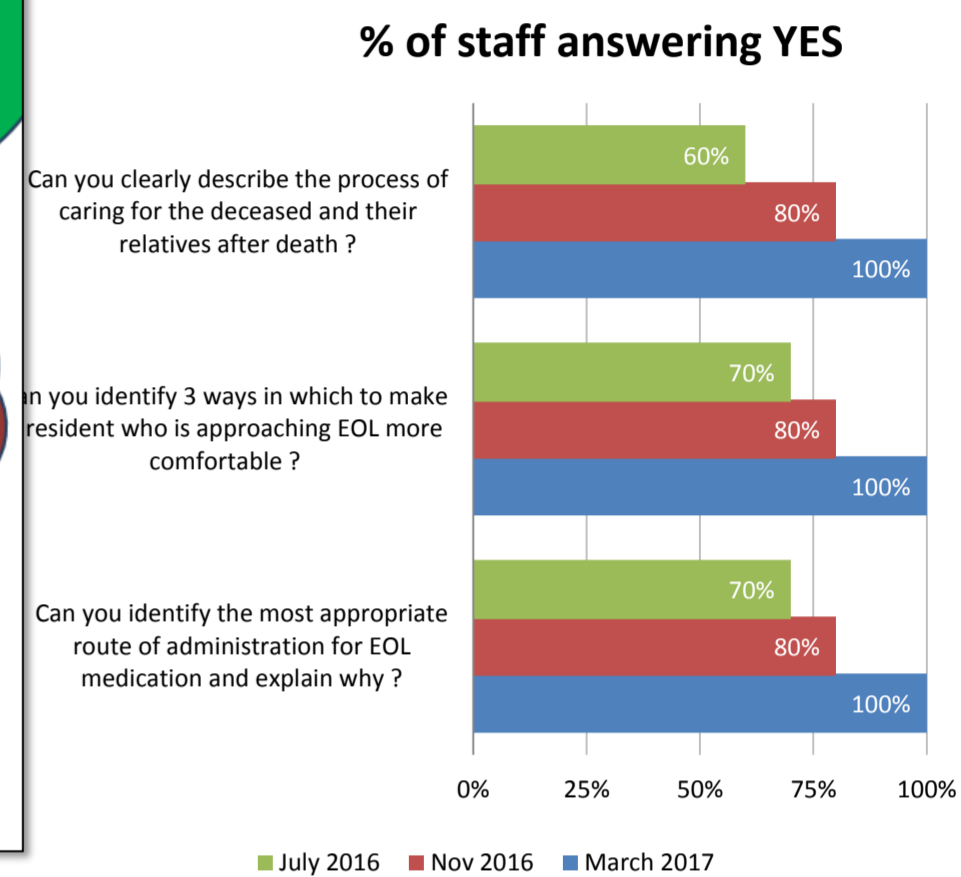


4.0 CHANGES MADE

During the period of October 2016 - September 2017 there was an increase in the number of residents who received symptom management via a subcutaneous syringe driver of 375%. This clearly demonstrates increased confidence in the care home nurses and good symptom control/management.



The care home staff have grown in confidence, so the quality of the information they are able to impart has improved. During the course of the project there has been a noticeable change in the conversations taking place between the care home staff and the palliative care teams.



2.0 Aim

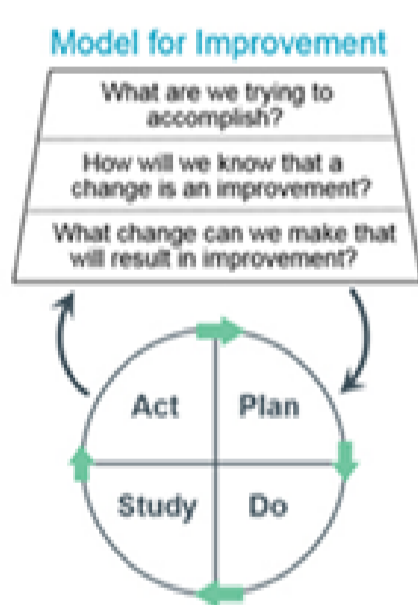
To improve end of life care for people living in care homes, by developing team working, increasing confidence in the workforce to deliver high quality care embedding good practice and evaluation



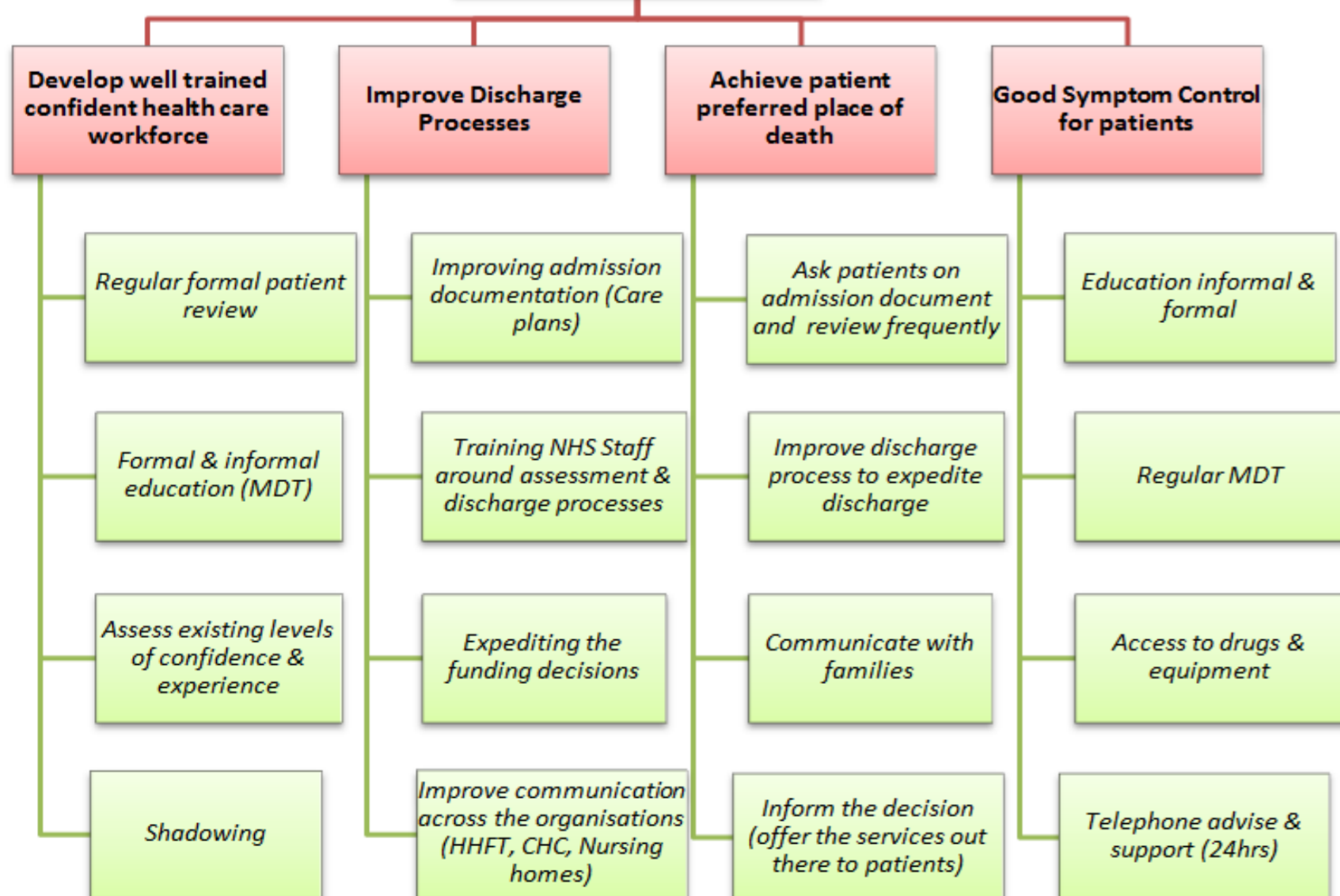
- Expediting discharge process
- Assessments by hospital team
- Ensuring all patients discharged with correct end of life medications and paperwork
- Weekly clinical review of patients in care home
- Bedside teaching for care home staff
- Care home staff attended HHFT palliative care education events
- Shadowing opportunities for care home staff at the hospice or hospital.

3.0 Project Design

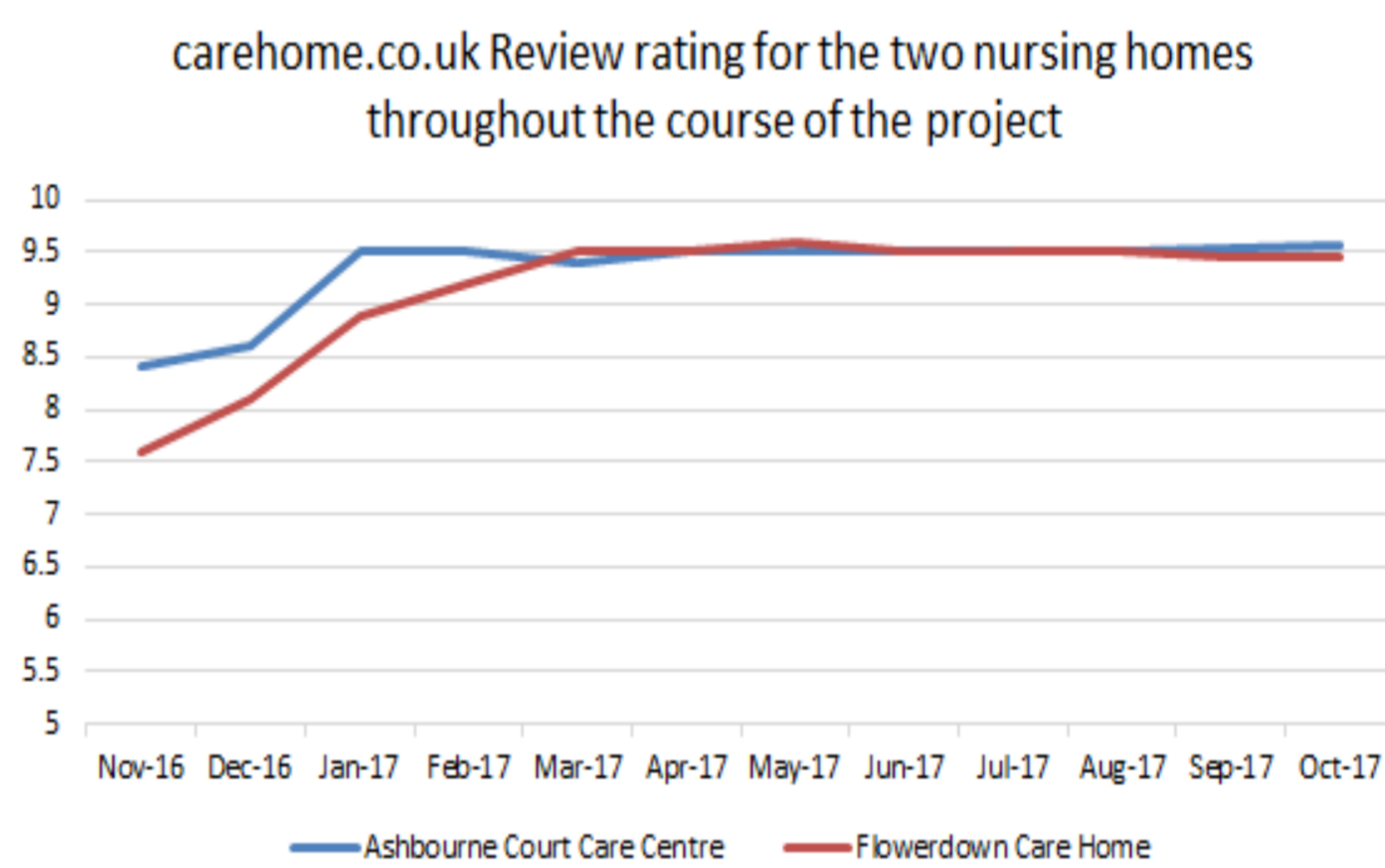
Through the study days with the Quality Improvement fellowship we adopted the Plan Do Study Act (PDSA) cycle, which allowed us to develop a plan based on the three questions as shown in the diagram below. We used a driver diagram which helped us to identify four distinct areas of improvement to concentrate on, and the actions required to achieve the project aim.



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5.0 Outcomes



Patients and family feedback was overwhelmingly positive. Both homes receive frequent feedback via the website: www.carehome.co.uk and an average score for the care they provide as shown in the run chart

- 100% felt significantly more confident when caring for residents at end of life.
- 75% can now recognise deterioration in their patients.
- Confident to set up a syringe driver.
- Recognition of complex grief in relatives and now able to liaise with agencies that can help.
- Perception that hospital admissions have been saved.

6.0 Next Steps

- Ideally we would like to be able to replicate the project in other care home settings
- Aware of implications for time and resources
- Recognise those involved were already interested and engaged so difficult to know whether results would be replicated
- Replicating the discharge process to non-commissioned beds