Sustaining Improved End of Life Care in Care Homes

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Background

A 'step down' project was designed to sustain an intensive palliative care programme undertaken within 7 care homes in Midlothian, Scotland(1).

This previous high facilitation model included a visit by a Clinical Nurse Specialist (CNS) to the care homes every 10-14 days along with the implementation of two main systems; the Gold Standards Framework (GSF) supportive/palliative care register and the adapted Liverpool Care Pathway (LCP). Key Champions were also appointed who attended a facilitative learning course and cascaded training to care home staff.

Key results from the initial project showed a significant increase in Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders (15% to 72%), Advance Care Plan (ACP) conversations (4% to 53%). There was a significant increase in the use of LCP (3% to 31%) and a decrease in unnecessary hospital deaths (15% to 8%).

Aims

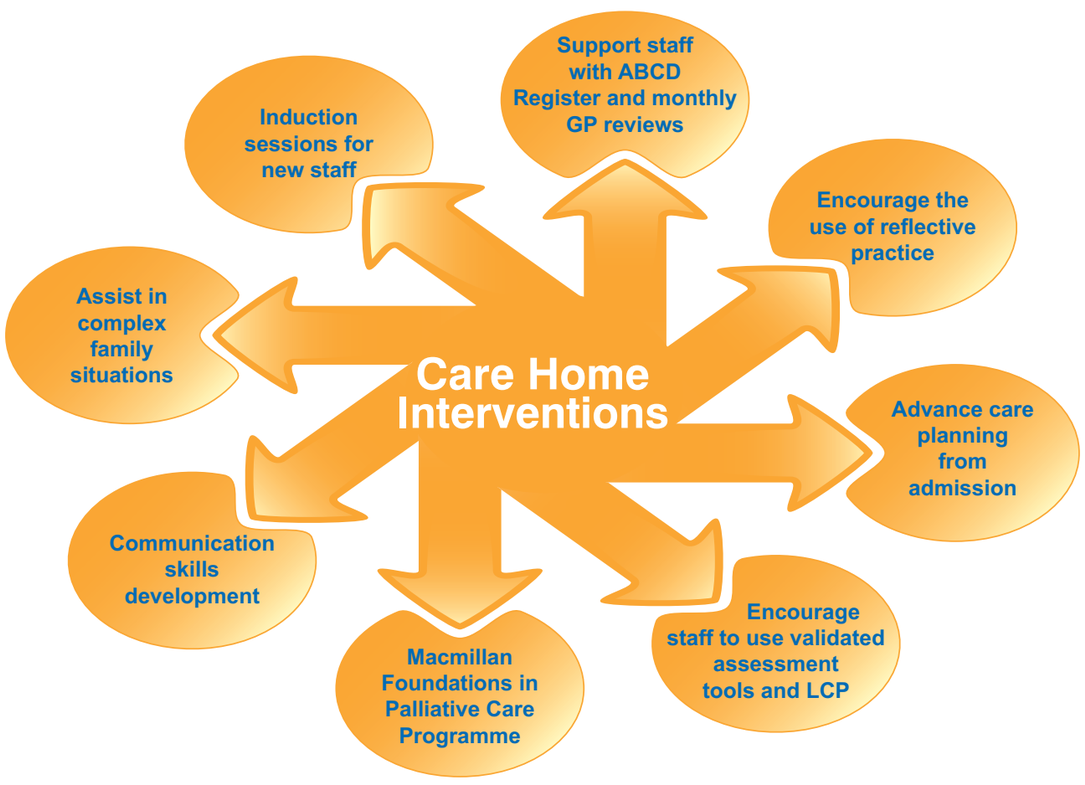
To demonstrate continued improvement in palliative care after the initial interventions, using a lower level facilitation model.

Method

Action research project.

- Two palliative care nurse specialists each spent one day per week working alongside care home staff and GPs providing support and training.
- Data were collected to measure the continued adoption of end-of-life systems/tools, attendance at and evaluation of education sessions.

Interventions



Results

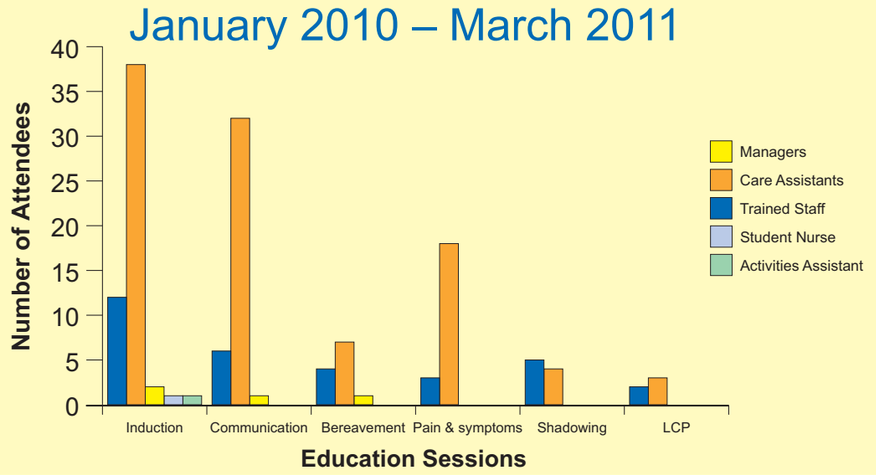
Data were gathered from 95 residents who died between January 2010 – March 2011.

	Step down Phase	Initial Phase
DNACPR	88%	72%
Advance Care Planning	92%	53%
LCP	47%	31%
Inappropriate Hospital Deaths*	3%	8%

** >88yrs with dementia, gradually deteriorating over a number of weeks – admitted to hospital and died within 2-3 days of pneumonia/ dehydration(1).*

Education Data

January 2010 – March 2011



- 88% of residents documented their preferred place of death as being the care home. 93% of these achieved their wish.
- 65% of residents had out of hours medical information available.
- 47% had anticipatory medicines prescribed.
- Only 4% of residents had complex palliative care needs requiring specialist advice.
- Staff report increased confidence in identifying and caring for dying residents and in supporting the families.
- Challenges included high staff turnover and difficulties allocating time for training.

Conclusion

The specialist nurses were able to strategically support and train staff to provide a high standard of end of life care to older people in care homes. Further work is needed to establish the optimum level of input and ongoing support required to maintain high quality palliative care within care homes.

Reference: [1]Hockley J; Watson J and Murray S. The Midlothian 'Gold Standards Framework in Care Homes' project. Edinburgh: University of Edinburgh; 2008.
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