





**Sustaining Improved
End of Life care in
Midlothian Care
Homes**

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Background

- Over 33,000 older adults in Scottish care homes
 - Average length of stay 1.5 years.
 - Aging population
- Policy
 - Making Good Care Better (2006)
 - Living and Dying Well (2008)
 - Better Care Every Step of the Way (2009)
 - Care Commission Bulletin (2011)



Background

Midlothian Gold Standard Framework in Care Home project (2006-2008)



- Key champions identified in each care home
- Intensive training of key champions
- In-house advice and training in the use of end of life care tools
- Specialist Nurse attended care home monthly meetings
- Reflective de-briefing



Ref: Hockley, Watson, Oxenham & Murray, *Pall. Med.* 2010

Background

- Midlothian Gold Standard Framework in Care Home project (2006-2008)



Do Not Attempt CPR documentation



Anticipatory Care Planning



Adapted Liverpool care pathway



Hospital deaths



Change in staff attitudes



Ref: Hockley, Watson, Oxenham & Murray, *Pall. Med.* (2010); Watson, Hockley and Murray, *End of Life Care* (2010)

The sustainability project (2009-2011)

Aim

To sustain the improvements in palliative care achieved during the original Midlothian project using a lower level of clinical nurse specialist input.



Midlothian Care Homes

Care Home	Size	Ownership	Beds	% Trained Nurses	No. of Mgrs during project
A	Large	Corporate	111	22%	1
B	Large	Corporate	78	29%	1
C	Medium	Corporate	56	20%	1
D	Medium	Corporate	61	24%	3
E	Small	Corporate	27	28%	2
F	Small	Corporate	19	43%	2
G	Small	Family	31	19%	1



Intervention – sustainability project

Education and training

- Education programme in palliative care
- One-to-one communications skills development

Support implementation of key processes

- Nurse specialist attended regular resident review meetings
- Supportive and palliative care register
- Encouragement to implement key end-of-life care tools
- Support to deal with complex family situations
- Reflective practice



Data collection

- **Audit of deaths** was completed with the Care Home Manager or Charge Nurse each month:
 - Resident prognosis (years/months/weeks/days)
 - DNACPR documentation in place
 - Liverpool care pathway (or equivalent)
 - Preferred and actual place of death
 - Out of hours information
 - External support required
- 132 residents died during the project.



Results

	Pre Midlothian GSF project (N = 95)	Midlothian GSF project (N = 133)	Sustainability project (N = 132)
DNACPR documentation	15%	72%	86%
Anticipatory care planning	4%	53%	96%
Died on care pathway	3%	31%	57%
Hospital deaths	15%	8%	23%

* Do Not Attempt Cardiopulmonary Resuscitation



Results

	Stable care homes (112 deaths)	Unstable care home (20 deaths)
DNACPR documentation	88%	70%
Anticipatory care planning	100%	75%
Dies on care pathway	57%	56%
Died in hospital	18%	50%



Discussion

- Care homes residents can be supported to die in their place of choice (the care home).
- Specialist palliative care providers have an important role to play in educating and training care home staff.
- Specialist palliative care input is not required for the majority of dying residents.



Discussion

- Much of the improvements in palliative care in care homes can be sustained using locally available resources.
- Key champions and a stable care home management structure is central to sustaining good palliative care in care homes.



Future plans

- Funding from the Robertson Trust and Marie Curie Cancer Care.
- Roll out program to promote and support palliative care in all care homes in South West Edinburgh.
- Ongoing evaluation



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