Community Palliative Care Nurse Specialist Model of Support to Care Homes

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Care and support through terminal illness

Background

Continued support from palliative care specialists is recognised as a way to improve end of life (EOL) care in care homes.[1,2] Community palliative care teams (CPCT) are well placed to take on this role. The community team from the Marie Curie Hospice Edinburgh supports 28 care homes (21 in south Edinburgh and 7 in Midlothian). The challenges of sustaining improvement are well documented[3] and the current intervention builds on the experience this team have gained in 2 previous projects.[1,3]

Aim

To develop an approach which supports continuous quality improvement in the care home setting that is realistic and achievable, and is tailored to the individual needs of each care home.

Intervention

Dedicated Community Palliative Care Nurse Specialist support

- A named Clinical Nurse Specialist from the CPCT was appointed to support each care home (CH). A phased approach to engagement with the CHs was undertaken.
- A profile was developed to gather information on the practices which influence the CHs current delivery of palliative care to allow the intervention to be tailored to need. *(Figure 1)*
- The dedicated CNS and CH manager/lead nurse from the CH use the information gathered to determine a level of intervention most appropriate and achievable for the individual care home.

Figure 1: ***Information gained from care home profile.***

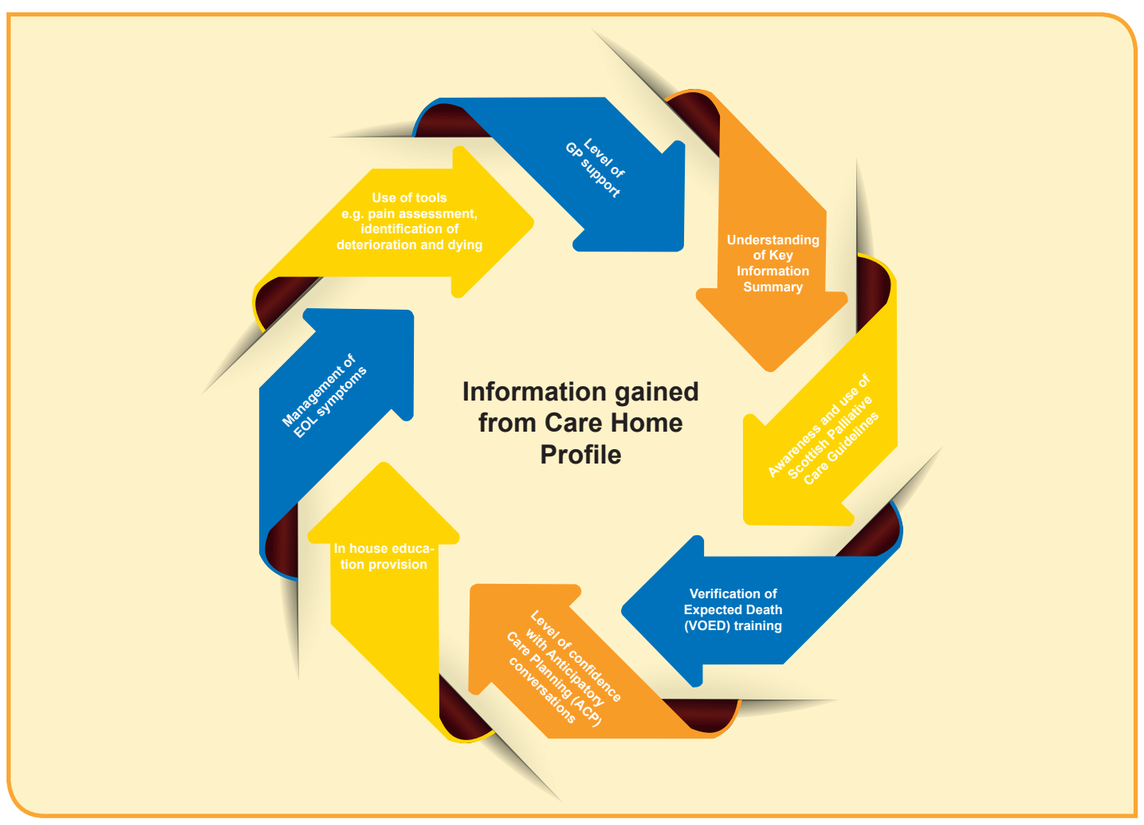


Figure 2: ***Model of collaboration between community specialist palliative care team and care homes.***

FULL INVOLVEMENT
Monthly palliative care review meeting incorporating register and use of Supportive Palliative Action Register Plus Intermediate Involvement.

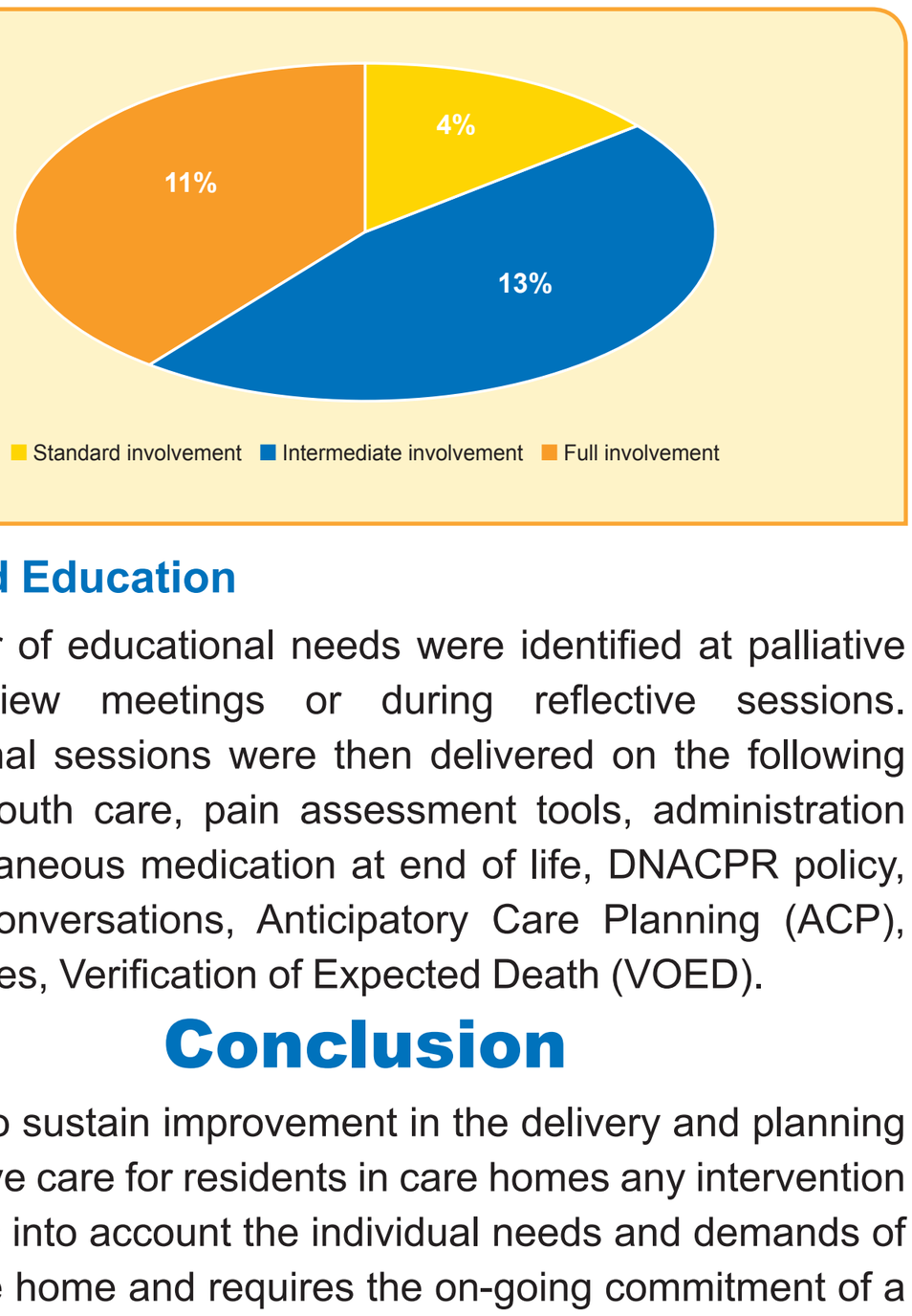
INTERMEDIATE INVOLVEMENT
Monthly meeting with lead/senior nurse, complete After Death Audit Form and use to facilitate reflective practice plus Standard Involvement.

STANDARD INVOLVEMENT
Specialist palliative care assessment and intervention for residents referred to the service. Provide targeted education, advice and support for staff, residents or families.

Level of involvement

- When first introduced to the project, in March 2015, all 28 CHs agreed in principal to 'Full Involvement'. In practice the CNSs have taken an individualistic approach with each home, which allows for variations over time. *(Figure 3)*

Figure 3: ***Number of care homes by level of involvement.***



Targeted Education

A number of educational needs were identified at palliative care review meetings or during reflective sessions. Educational sessions were then delivered on the following topics: mouth care, pain assessment tools, administration of subcutaneous medication at end of life, DNACPR policy, difficult conversations, Anticipatory Care Planning (ACP), Last Offices, Verification of Expected Death (VOED).

Conclusion

In order to sustain improvement in the delivery and planning of palliative care for residents in care homes any intervention must take into account the individual needs and demands of each care home and requires the on-going commitment of a named CNS who will take a flexible continuous improvement approach to change.

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References: 1. Hockley J, Watson J, Oxenham D, Murray SA. The integrated implementation of two end-of-life care tools in nursing care homes in the UK: an in-depth evaluation. Palliative Medicine. 2010;24(8):828-38. 2. Gardner H, Finucane A, Stevenson B, Oxenham D, Barker B, Partington D, Muir L, Gibson H, Montgomery E, Murray S (2013). The South Edinburgh care homes project – A hospice led intervention to improve palliative care for care home residents. Poster presented at Help the Hospices Annual Conference, Bournemouth. 3. Finucane AM, Stevenson B, Moyes R, Oxenham D & Murray SA. (2013) Improving end-of-life care in nursing homes: Implementation and evaluation of an intervention to sustain quality of care. Palliative Medicine, 27(8): 772-8.