Interim Report

Steps to Success – achieving quality end of life care in Lambeth and Southwark residential care homes

Louisa Stone

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Background

Nineteen per cent of deaths in England occur in a care home (DoH 2012). Six-seven per cent of these occur in care homes without nursing (Tebbit 2008), emphasising the need for good end of life care in these homes. With the projection of an aging population (Rutherford 2012) it is likely that the number of people living and dying in a care home will increase. It should also be noted that residents who are admitted to care homes are becoming frailer (Froggatt et al 2008).

When frail older people are naturally coming to the end of their lives, we know that hospital admission is rarely beneficial (Morrison & Sui 2000). Staff in residential care homes care for those who are dying with support from District Nurses (DNs), GPs and when necessary their local Specialist Palliative Care service. The importance of inappropriate hospital admissions and a person dying in their preferred place of death are re-iterated by the government (DoH 2012).

Steps to Success

The Department of Health’s End of Life Care Strategy (2008) highlighted the need on providing good quality end of life care in all settings. The ‘Steps to Success’ programme is adapted from the National End of Life Care Programme’s ‘Route to Success in End of Life Care – achieving quality end of life care in care homes’ (NEoLCP 2010). It requires each residential home to work through six steps over the period of a year. The ‘toolkit’ containing the documentation is electronic. Participating residential care homes download the documentation. The residential care homes were assisted throughout the year by a care home facilitator in end of life care who visited regularly to help them implement the six steps and role model where required. The key objectives for the programme were that:

- care home staff recognised dying residents and planned care accordingly
- care home staff had increased confidence to care for dying residents in the residential care home setting
- care home staff developed good collaboration with their GP’s and DN’s
- residents and families have had the opportunity to discuss preferences and wishes/Advance Care Plan
- tools to improve quality of life e.g. pain assessment were implemented

The St Christopher’s Steps to Success programme was successfully piloted in four residential care homes in Lewisham in 2011. Since then all remaining homes in Lewisham completed the programme.

Four of the ten residential care homes in Lambeth and Southwark committed to the programme for the year 2012-2013 and the remaining six have been recruited to commence the programme in December 2013.

Audit data was collected for the year prior to the programme (Sept 2011 – Aug 2012).
Interim evaluation

This interim evaluation reports on the implementation of the Steps to Success programme within the four participating residential care homes.

Step 1 - Assessment, care Planning and Review

This step involves the care homes setting up a system that enables staff to recognise dying residents and proactively plan their end of life care. A Supportive Care Register was used to enable them to review all their residents monthly (Appendix 1), along with the Prospective Prognostic Planning Tool (PPPT) (Appendix 2). These tools helped staff to recognise change in their resident’s condition and plan their care accordingly.

All four homes implemented the Supportive Care Registers and PPPT and reviewed their residents monthly. Each home now shares this information with their GP. One home attends the GSF primary care meeting whilst the others update the GP and District Nurses. The District Nurse attends the meeting in one home and liaises with the GP.

Step 2 – Discussion as end of life care approaches

In relation to Advance Care Planning (ACP) all four homes use their organisations forms to document preferences and wishes. One home adapted theirs as a consequence of attending the Steps the Success programme. The facilitator’s assistance varied between homes according to preferences and need but it included: role modelling advance care plan conversations, providing teaching sessions on ACP and role play around a scenario. The DNs were invited but unable to attend due to staff shortages and high workload.

During this year of the programme, audit data continued to be collected (Sept 2012 – Aug 2013).

Residents dying in the residential home increased from 44% (n=8) to 50% (n=13). Do Not Attempt Cardio Pulmonary Resuscitation (DNaCPR) increased from 6% (n=1) to 27% (n=7) and Advance Care Planning (ACP) increased from 11% (n=2) to 39% (n=10). Although it should also be noted that not all residents with ACP or DNaCPR have since died.

Step 3 – Care in the last weeks/days of life

This step required homes to structure the care they gave to their residents in the last weeks/days of life. It was intended to train 80% of the staff to use an integrated care plan for the last days of life (ICP). Whilst discussions were occurring between the nurse consultant for the Care Home Project Team (Jo Hockley) and community to look at the smooth integration of this between the care homes and DN team the publication of the ‘more care less
pathway, report by Baroness Julia Neuberger occurred (2013). A meeting with the DN lead is planned in November prior to a final decision being made. The residential care homes work with the community DNs and so are dependant not only on their assistance but guided by the documentation they use. Meanwhile a scenario was used to educate staff in all the homes on care in the last weeks/days of life.

**Step 4 – Care after Death**

After a death reflective debriefings with staff have been introduced into all the homes. Staff have found these supportive as well as providing an opportunity to learn. All four homes have been invited to take part in an audit using the Family Perception of Care Scale questionnaire to evaluate the experience of relatives who’s loved one has died in the care home. This is a validated tool for use in care homes. This audit commences in January 2014. All homes give residents and staff the opportunity to attend funerals and often offer refreshments post funeral in their care home.

**Step 5 – Delivery of high quality care**

This step focused on the use of symptom assessment tools. All home used pain assessment tools, although only one had a tool for residents with dementia. As 80% of residents in care homes have dementia or a significant memory problem (Quince 2013) the Doloplus 2 assessment tool has been introduced to the other homes. The use of this tool has been delayed in two homes until the trainer and clinical lead of the company approve its use.

Training sessions on identifying pain and use of assessment tools have been held for staff in the care homes as well as role modelling of pain assessment tools.

Depression scales (Geriatric Depression Scale and Cornell Scale for Depression in Dementia) have also been introduced into the homes and role modelled where appropriate.

As described in step 4 all homes are being encouraged to use the Family Perception of Care questionnaire.

**Step 6 – Good co-ordination of care**

GPs review residents in three of the care homes weekly. The other has to contact the GP surgery and the resident is triaged by the Practice Nurse. All GPs are aware of the Steps to Success programme. They are updated after each Supportive Care Review meeting either verbally or in writing. One home has attended the GP three monthly palliative care meeting. The Nurse Consultant Guys and St Thomas’ Community Services (GSTT) has initiated monthly meetings between the end of life CNS and DNs which the facilitator attends where
appropriate. Staff in residential care homes are aware of Co-Ordinate My Care and prompt GPs to register the residents accordingly.

The facilitator has arranged meetings between DNs and care home managers in two of the care homes to discuss how end of life care is implemented and can be supported in the homes. The facilitator is in discussion with the Nurse Consultant for GSTT to see whether DNs/community nurses would like to attend future Macmillan Foundations in Palliative Care training sessions alongside the residential care home staff.

The facilitator and nurse consultant have met with commissioners at Lambeth and Southwark CCGs to inform them of the project. This led to the facilitator being invited to present at the Southwark Board for Older Persons and to the lay commissioners at Age UK Southwark group.

**Plan for 2014**

**For homes currently on the Steps to Success programme**

To complete the Steps to Success programme the four homes are compiling a portfolio of evidence to illustrate how they have implemented each step of the programme. These homes then join a sustainability programme. This consists of:

- Induction days – held twice a year for all new members of staff.
- Macmillan Foundations in Palliative Care for Care Homes – held twice a year for all health care assistants and home managers.
- Half-day seminars for managers/care managers – held quarterly.
- Continued facilitator visits.

Prior experience with the Gold Standards Framework in Care Homes with nursing care homes has shown that change takes time. Changes when implementing this programme occurred in the second year of the programme. Nolan et al (2008) point out that in order to embed change a long term commitment is required. Without such long term commitment cultural change is difficult to achieve or sustain.

**For remaining residential care homes**

The remaining six residential care homes in Lambeth and Southwark start the Steps to success programme in December 2013.
Future - 2014 onwards

- Plans need to be made this year for sustainability of the Steps to Success programme. The implementation of this programme in other CCGs indicates the need for an on-going sustainability programme which requires on-going funding.
- There needs to be greater integration of the community services with the residential care homes
  - Highlighting need for residents to be added to palliative care register earlier e.g. in last months of life not weeks.
  - Need for district nurse to engage in ACP (preferences and wishes and Health Choices) and resuscitation conversations.
- Need to plan for on-going maintenance and monitoring of the residential care homes portfolio of evidence
- To ensure palliative care is part of Key Performance Indicators (KPI).
Reference List

Quince C (2013) Low expectations: Attitudes on choice, care and community for people with dementia in care homes Alzheimer’s Society


National End of Life Care Programme (2010) The route to success in end of life care – achieving quality in care homes National End of Life Care Programme


Tebbit P (2008) Capacity to care – A Data Analysis and Discussion of the Capacity and Function of Care Homes as Providers of End of Life Care The National Council for Palliative Care