FoNS Improvement Insights

Care Home at Night, Evening and Weekend – Making Residents' Choices Happen

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Project background

In the United Kingdom (UK) 500,000 people live in care homes, where the incidence of frailty and co-morbidities is increasing. In 2008, the National Audit Office identified a quarter of resident deaths occur in hospital with at least 40% having no identified medical need to be there.

The care home where the project originated is located in a large West Yorkshire city and at the start of the project it was managed by the largest independent provider of long term care in the country with over six hundred homes. The home has 40 beds for residents requiring nursing care but there are also a small number of residential beds. There were six other care homes managed by the same independent provider, who were also involved in this project.

The project was triggered by a distressing incident within the care home when nursing staff felt 'powerless' to stop a resident being unnecessarily transferred to hospital, and who subsequently died shortly after admission to the Accident and Emergency department.

Aim and objectives of the project

The aim of the project was to gather the experiences and wishes of residents relating to end of life care and enable them to be respected in the event of a resident's condition deteriorating, thereby reducing inappropriate admissions.

To achieve this, the objectives of the project were to:

- Understand residents' experiences of good nursing care
- Gather and understand residents' wishes regarding future treatment plans
- Develop a process for using these wishes within a clearly documented format
- Develop a system of early recognition and intervention to prevent crisis events

Key activities and outcomes of the project

Following support from FoNS, appreciative inquiry was adopted as an approach within the project. This approach focuses on what is valuable in what people do and how this can be built on. A template called "Tell Me Your Story" was drawn up to facilitate recollection of events where staff felt that they had made a difference to the care of a resident. Many stories were recounted verbally but thirteen were also written down using the template. The stories were analysed by the project group, with members identifying the themes that appeared to make a difference to the residents. Three common themes emerged as making a difference:

- Knowing what a resident wants in terms of future care and ensuring these wishes are clearly documented in a format which will be recognisable and credible to clinicians involved in the resident's care
- Recognition and anticipation of potential problems and early intervention to prevent crisis events
- Confidence of staff when talking to other people involved in the resident's care whether family members, other staff, doctors or out of hours providers and a willingness to act as an advocate for the resident when required. Specifically confident staff were able to challenge plans that they felt were not in the resident's best interest

Changes implemented as a result of the project were a positive acceptance by nursing staff of the importance of and use of Advance Care Planning, ensuring documentation such as Do Not Attempt Resuscitation Orders are in place and early recognition of potential deterioration using the "Stop and Watch" tool and SBAR communication tool. As the project progressed, the independent provider went into financial administration forcing significant changes in the organisational management of the homes. Because of this, the planned formal evaluation of the project using the number of crisis/inappropriate hospital transfers was not achieved. Despite this informal feedback from a small number of patient case studies suggests that the experience of being involved in the project and the tools that have been introduced have had a lasting effect on nursing practice within the care home. In addition, involvement in the project has opened up opportunities for the project leader to share good practice with a number of other agencies and providers.

Implications for practice:

- Using an appreciative approach to understand what went well in end of life care was welcomed by staff as an alternative to unpicking what went wrong in an incident
- It is possible to change practice in the light of major organisational change but requires a flexible and creative approach
- The 'stop and watch' tool and SBAR method can empower staff to be more confident to act as the patient's advocate

A full project report including references can be accessed from: http://fons.org/library/report-details.aspx?nstid=34970

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