Improving end-of-life care in nursing homes: an innovative model of education and training

Palliative care professionals should aim to improve the end of life for all, including those who die in care homes. In 33 London nursing homes, a palliative care team has implemented an innovative model of training to help staff provide better end-of-life care to residents. **Corinne Campion, Ash Kassaye, Susie Sutherland, Maureen Carruthers, Julia Riley, Jayne Wood** and **Anna-Marie Stevens** tell us more

The NHS End of Life Care Programme was set up in 2008 to improve the quality of care for people at the end of life in England.[1] One of its aims was to help more people live and die in their place of choice. Information about peoples' wishes is often not captured or shared, and a lack of services to support them at home can lead to unplanned and unwanted admissions to hospital. Improving end-of-life care and ensuring people die where they want to die by offering a greater choice in the place of care and death is not only beneficial for those who are dying and their families; it has been shown that it can decrease the number of emergency admissions to hospital in the last week of life.[2]

For some people, the preferred place of care and death is a care home, which may be a nursing or a residential care home. Care homes play an important role in looking after older people at the end of life. In England, 19.6% of those who die are care home residents, rising to 30% of those aged over 85. Each year, on average, 41,969 people die in a nursing home and 32,138 in a residential care home.[3] People live longer, often with complex needs and with co-morbidities such as dementia.[4,5] Furthermore, an increasing number of people die in care homes. All these factors combined mean that we need to have a closer look at the quality of end-of-life care in care homes.

Many care homes provide compassionate, competent and co-ordinated care, but many are beleaguered by chronic staff shortages, high staff turnover and inadequate reimbursement, all of which can adversely affect the quality of care. Local hospices provide specialist palliative care to care homes, and data about this involvement are starting to become available.

Since the launch of the End of Life Care Strategy,[1] the Department of Health has introduced different approaches and strategies to ensure high-quality end-of-life care in all settings, and one of the key aspects is the education of health- and social care staff. Here we describe an innovative model of education and training for nursing home staff set up in local nursing homes in two London clinical commissioning groups (CCGs) to improve end-of-life care for residents.

How does the model work?

The model was set up through a collaboration between the Royal Marsden NHS Foundation Trust and community services in the two London CCGs of Sutton and Merton. After preliminary work from October to December 2013, the model was rolled out from January 2014 onwards in all 33 nursing homes located in Sutton and Merton CCGs. Initially, funding for the project came from Sutton and Merton

Key points

- In England, 19.6% of those who die live in care homes, so care home staff need to be trained to provide good end-of-life care.
- A team from the Royal Marsden NHS Foundation Trust in London have set up an innovative model of training to help nursing home staff, as well as local GPs, improve end-of-life care for residents.
- The model has been rolled out in 33 nursing homes in Sutton and Merton. It encompasses education and training, clinical rounds, advice and guidance, communication, and care co-ordination.
- Nursing home residents are offered an electronic end-of-life care plan on Coordinate my Care (CMC). Data show that around 85% of people who have a CMC record die in their preferred place.
- The training model is being extended to residential care homes, and potentially to care homes for people with learning disabilities.

The training model is designed to help nursing home staff improve the end-of-life care they provide to residents and families

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CCGs, and currently funding continues to be provided by Sutton CCG.

Figure 1 shows different elements composing this model of training in end-of-life care for nursing home staff. The idea is to improve the competence and efficiency of staff so that they can, in turn, improve the experience of residents and families in the last year of the resident's life.

The team tasked with implementing the model consists of a palliative care consultant, a palliative care nurse consultant, a palliative care matron and three clinical nurse specialists (CNSs) from the Royal Marsden NHS Foundation Trust. Its remit is to help participating nursing homes, as well as local GPs, improve end-of-life care for residents and their families. Box 1 gives a real-life example of how the model can help improve care.

The model encompasses five key aspects: education and training, clinical rounds, advice and guidance, communication, and care co-ordination.

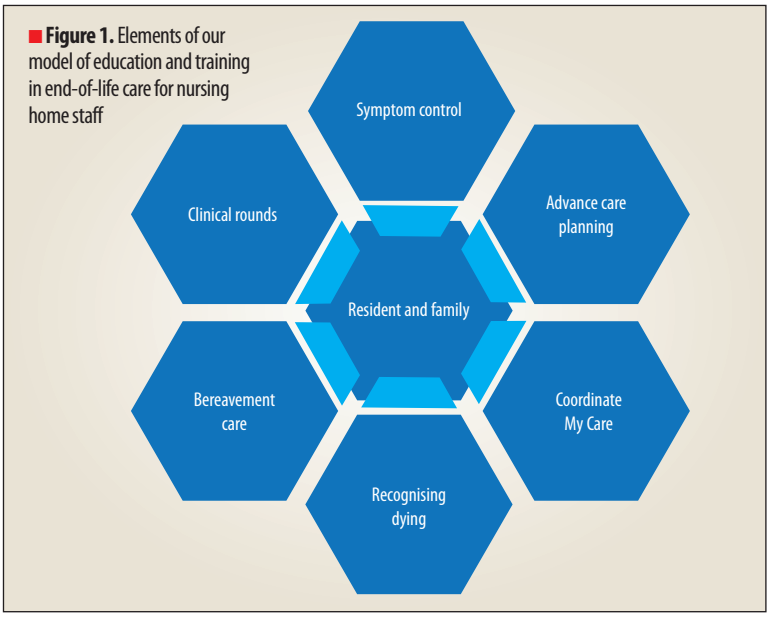


Figure 1. Elements of our model of education and training in end-of-life care for nursing home staff

Education and training

The education programme is set at foundation level so that healthcare assistants are able to participate alongside registered nurses. There are five sessions in total, lasting an hour each, and the topics covered are: recognising dying, advance care planning (ACP), co-ordination of care, symptom control, and bereavement care. The teaching methods combine theory, case scenarios and reflection. The sessions are repeated in each nursing home until all staff have attended all sessions. Once they have completed all sessions, staff receive a certificate of attendance.

Generally, nursing home staff have evaluated the training sessions positively. Several nursing home managers have asked that we also train their non-clinical staff, who often become emotionally involved with

residents, especially when these have been living in the home for a long time.

Clinical rounds

The CNSs on the team undertake clinical rounds with the nursing home staff to help them identify residents who are becoming more frail and showing signs of deterioration that may indicate they are approaching the terminal phase. These clinical rounds are held once a month.

If changes occur between two rounds – for example, if staff think a resident has entered the dying phase – the CNSs will do an extra visit to support patient and staff, and where necessary the family.

The information gathered during the rounds allows the CNSs to help the nursing home care team address residents' end-of-life care needs. The rounds also provide an opportunity for role modelling and experiential learning at the bedside, thus helping staff to put into practice the theoretical knowledge acquired in the training sessions. The clinical rounds continue in all nursing homes after the training has ended, so this part of the project is ongoing.

Advice and guidance

The team provides nursing home staff and local GPs with advice on symptom control and drug prescribing. The nursing homes receive a resource folder which contains copies of the training sessions as well as guidance on assessment tools, ACP, anticipatory medications, and so on.

Box 1. Margaret's case

Margaret* was 97 years old. After a series of falls, she was admitted to hospital with a fractured neck of femur. Post-operatively she was transferred to a local nursing home. She had recently taken a course of oral antibiotics for a third chest infection. She was frail, had diabetes and a poor appetite. Her mood was low and, at meal times, she declined joining other residents in the dining room, preferring to stay in her room.

Following a teaching session on 'recognising dying', the nursing home staff identified Margaret as a resident to be reviewed on the next clinical round. During the round, the clinical nurse specialist (CNS) used the SPICT (Supportive and Palliative Care Indicators Tool) to assess and discuss Margaret's condition. This tool takes into account indicators such as long-term nursing home placement, deteriorating health and weight loss for prognostication.

Despite the recent deterioration in her physical health, Margaret was able to express her wishes. She was adamant that she did not want to be readmitted to hospital if she deteriorated further, preferring to stay in the nursing home. She wanted reassurance that her wishes would be respected and asked for them to be written down.

It was suggested that her son and daughter come to the home for a family discussion around advance care planning (ACP). Margaret had mental capacity but, because of her recent poor health, her children had applied for joint power of attorney for health and finance issues. The CNS helped Margaret and her family complete the ACP document. Nursing home staff were encouraged to witness these discussions in order to get a clear view of the resident's and family's wishes, as well as for training and role modelling purposes.

The GP was informed of Margaret's advance care plan and came to the hospice to discuss a 'Do not attempt cardiopulmonary resuscitation' (DNACPR) order with Margaret and her family. They were reassured that having a DNACPR order would not mean that all care would be stopped, but only that CPR would not be commenced in case Margaret's heart stopped. A DNACPR form was signed and placed in Margaret's notes.

With Margaret's consent, an electronic Coordinate My Care urgent care plan was also created. Margaret and her family were reassured that this plan would put her at the centre of care, enable her to remain at the nursing home and avoid emergency admissions to hospital.

* The name has been changed to protect patient confidentiality.

Communication

During the training, communication with residents, families, care home staff and healthcare professionals is highlighted as being of utmost importance. The CNSs explain to nursing home staff the importance of sensitive and compassionate communication with residents and those close to them, as well as the need for clear and timely communication with healthcare professionals.

To improve communication, clinical rounds are sometimes timed to coincide with a GP's visit or the presence of a relative or informal carer, especially if the nursing home staff feels that they would benefit from a discussion with the CNSs, in particular about their loved ones' wishes for future care.

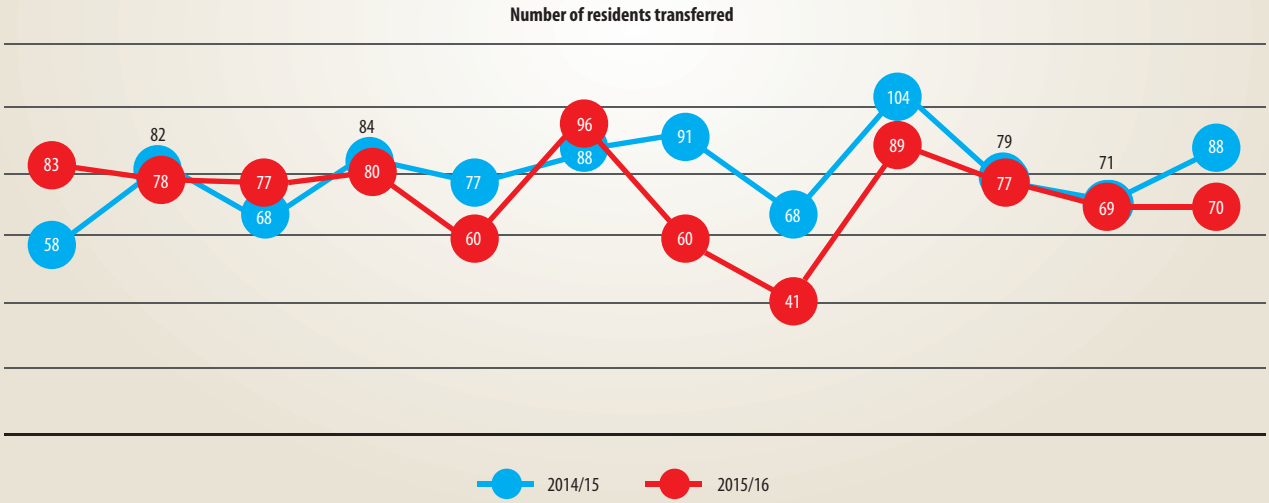
Care co-ordination

The team regularly attends Gold Standard Framework meetings with the GP practices attached to the nursing homes: this enables multidisciplinary working with hospice nurses, community nurses and other health- and social care workers. The meetings provide an opportunity to discuss residents who have deteriorated and potentially prompt the creation of individual electronic records documenting residents' end-of-life care wishes, using Coordinate My Care (CMC).[6]

CMC is a clinical service underpinned by an electronic solution. Launched in December 2010, it has been rolled out – and is now available – across London. It puts patients at the centre of any planned care, recording their wishes about how and where they want to be

	Number of residents transferred			
Month	2014/15	2015/16	Difference in number	Difference in percentage
April	58	83	25	43.1%
May	82	78	-4	-4.9%
June	68	77	9	13.2%
July	84	80	-4	-4.8%
August	77	60	-17	-22.1%
September	88	96	8	9.1%

	Number of residents transferred (continued)			
Month	2014/15	2015/16	Difference in number	Difference in percentage
October	91	60	-31	-34.1%
November	68	41	-27	-39.7%
December	104	89	-15	-14.4%
January	79	77	-2	-2.5/%
February	71	69	-2	-2.8%
March	88	70	-18	-20.5%
Total	958	880	-78	-8.1%



cared for and die. Their electronic record and care plan can be accessed by all health- and social care professionals involved, including out-of-hours GPs, community nurses and ambulance services.

CMC has adopted the NHS maxim 'Nothing about me, without me', and this applies to nursing homes as to any other setting, so nothing goes on the record without the resident's consent. If residents no longer have mental capacity to make decisions about their care, a best-interest decision is made by their GP following discussion with the family and appropriate members of the multidisciplinary team. The CNSs help nursing home staff to register residents on CMC. At the GP practice, the CMC record is managed by the GP or an administrative member of staff who ensures it is approved by the GP.

How does Coordinate My Care help?

Identifying people who are approaching the end of life as early as possible allows health- and social care professionals to open discussions around ACP with them and their families. ACP discussions and records help ensure that people die in comfort and with dignity, which is a central tenet of end-of-life care.[7] ACP has a positive impact, not only at the time of its implementation but also after the person's death when the family goes through bereavement.[8] It has also been shown that tailored, ongoing educational support and collaborative working with care homes helps to improve standards of care for people at the end of life.[9]

Data show that people who have an end-of-life care record – for example, on CMC – and have stated that the preferred place of death is their home or a nursing home usually die in their preferred place. Of the 3,050 people who died between the third quarter of 2013/14 and the first quarter of 2014/15 in nursing homes in Sutton and Merton CCGs and had a CMC record, around 85% died in their preferred place, which is well above our target of 80%. Only 18% died in an acute hospital setting. Our data also show that, in Sutton CCG, the

Figure 2. Number of nursing home residents transferred to hospital by ambulance in Sutton Clinical Commissioning Group between April 2014 and March 2016

introduction of CMC records coincided with a reduction in the number of contacts with the ambulance service and of transfers to hospital. There were 8.3% fewer calls from nursing homes to the ambulance service in the year following the implementation of the training model and the introduction of CMC records; the number of calls went down from 1,109 in 2014/15 to 1,017 in 2015/16 – that is, 92 fewer calls. There was also a 8.3% reduction in the number of ambulance transfers of nursing home residents to hospital: the number went down by 78 between April 2014 and March 2016 (see Figure 2). The average cost of an ambulance transfer to hospital being £500, this represents an estimated saving of £39K.

The ambulance crews still took the same percentage of residents to hospital when they were called (that is, 86%). We believe that further training is needed to give them the confidence to look at residents' care plans and determine whether or not admission to hospital is appropriate.

At present, ambulance crews have to call the ambulance hub to access residents' CMC care plans by telephone. Work is in progress for them to have access to these care plans on their mobile devices in the ambulance. The aim of training ambulance crews and easing their access to care plans is to further reduce unnecessary admissions to hospital.

How are we doing?

In 2015, our team delivered 208 training sessions. Merton and Sutton CCGs have set key performance indicators (KPIs) to evaluate the quality of the support provided by our team to the local nursing homes. The KPIs measure the number of:

- visits to each nursing home
- nursing homes where a monthly clinical round is undertaken
- nursing homes where training sessions are conducted
- nursing home residents offered an urgent care plan on CMC
- nursing home residents with a CMC urgent care plan who die in their preferred place.

The team has achieved its targets for the financial year 2015/16 and has been commissioned to roll out the training model to residential care homes in Sutton CCG; this new phase is under way. The team has also been commissioned by Sutton CCG to conduct a pilot study in 11 care homes for people with learning disabilities. This is due to start in September 2016.

Several models of ACP and digital documentation on CMC for nursing home residents are currently being implemented in 30 CCGs in and around London.

Summary

The end-of-life care team at the Royal Marsden NHS Foundation Trust have set up an innovative model of training for nursing home staff underpinned by theoretical knowledge and role modelling. The aim is to help staff improve end-of-life care for residents, in particular to recognise when they may be approaching death and help them state their wishes and preferences. As part of this scheme, residents are offered ACP and an electronic care plan on CMC. All 33 nursing homes in Merton and Sutton CCGs have now completed staff training. The project is being extended to residential care homes, and potentially to care homes for people with learning disabilities.

Declaration of interest
The authors have no conflicts of interest relating to the publication of this article.

References

1. Department of Health. *End of Life Care Strategy: promoting high quality care for all adults at the end of life*. London: DH, 2008. www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life (last accessed 08/07/2016)
2. National Audit Office. End of Life Care. 2008. www.nao.org.uk/report/end-of-life-care (last accessed 08/07/2016)
3. National End of Life Care Intelligence Network, 2010. www.endoflifecare-intelligence.org.uk/home (last accessed 08/07/2016)
4. Addicott R, Hiley J. *Issues facing commissioners of end-of-life care.* The King's Fund, 2011. www.kingsfund.org.uk/publications/issues-facing-commissioners-end-life-care (last accessed 08/07/2016)
5. Alzheimer's Society. *Dementia 2012: A national challenge.* Alzheimer's Society, 2012. www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1389 (last accessed 08/07/2016)
6. www.nhsiq.nhs.uk/8078.aspx (last accessed 08/07/2016)
7. Henry C, Seymour J. *Advance Care Planning: A Guide for Health and Social Care Staff.* Department of Health, End of Life Care Programme, National Council for Palliative Care, 2008. www.ncpc.org.uk/sites/default/files/AdvanceCarePlanning.pdf (last accessed 04/08/2016)
8. Waller S, Dewar S, Masterson A, Finn H. *Improving environments for care at end of life – Lessons from eight UK pilot sites.* The King's Fund, 2008. www.kingsfund.org.uk/publications/improving-environments-care-end-life (last accessed 08/07/2016)
9. Henry C, Hayes A. Providing high-quality end-of-life care universally. *Nursing Times* 2013; **109:** 16–18.

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