

Service Evaluation of End of Life care arrangements of a Hospice to Care Home initiative

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Evaluating Rotherham Hospice's Care Home Initiative for End of Life Care.



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The aims of this evaluation project were to:

- Evaluate if and how the introduction of the pilot has provided a responsive service
- Explore how the planned education packages influenced decision-making
- Explore how the bespoke education packages influenced decision-making
- Inform NHS Rotherham of the cost benefit and qualitative evaluation to enable further decisions to be made.

The outputs to be measured were:
Patient and care home activity data,
Planned and bespoke education access data, Calls to the advice line.

The care home pilot aimed to work with all care homes in Rotherham (n=45) and provide a multi-stepped service to them

Care home staff had direct access to Hospice services 24 hours a day, 7 days a week

The Hospice at Home team supported people to stay in their care home, bringing appropriate hospice support to them.

The Hospice worked with care home staff to provide education and support staff with decision making which prevented unnecessary hospital admissions.

The hospice continued to visit responsively day and night to support staff and residents with palliative care needs during their illness

A critical analysis of the type, structure and content of the education provided was undertaken via semi-structured focus group interviews with a cohort of Care Home Staff,

A critical analysis of the data available to support both activity and individual patient, care home and borough-wide outcomes was undertaken

100% of respondents (n=245) said they would recommend the hospice's training course they attended to a care home colleague

The team spent an average of 65.9 hrs of face-to-face time with these care home patients per month, equating to an average of 110 minutes per patient.

These 'advice calls' included an average of 41.1 (range 5-99) per month to care homes. Calls to the advice line also resulted in an average of approximately 300 patient visits by a qualified hospice nurse. Of these, an average of 30.5 (range 1-68) visits per month were to care home patients.

All the care home staff talked about an improvement the hospice support had made to their practice and ultimately to the end of life experiences of the residents.

Hospice staff reported that, as more and more nursing homes became aware of the project they had noticed an increase in the number of people being referred to the services.

There was a consensus that both the education strands had improved the confidence of care home staff in their everyday practise and in using the hospice's services directly

Precise costing estimates were difficult to obtain, however, the crude financial impact of these outcomes was calculated by using the figures from Georgioui and Bardsley (2014) for each admission (£4,580). Over the 12-month period (October 2017-September 2018) this equated to a saving of £1,777,040. Similarly, using a cost estimate of £147 per GP visit, the team also saved £17,493

Between October 2017 and September 2018 a total of 388 admissions and 119 GP visits were avoided through the team's input to care homes.

It was not possible to identify any statistically significant associations between the team's activity metrics and avoided GP contacts or early discharges.

A study from Bukki et al. (2016) with a range of nursing home staff found they were willing to care for dying residents, but expressed concerns which included issues such as workload, and a lack of training, knowledge and skills.

Care home residents determined to be in the last phase of life can be expected to experience multiple symptoms and to have physical, psychological and spiritual needs (Brinkman-Stoppelenburg et al., 2015).

Mitchell et al. (2016) situated in Northern Ireland, similarly explored care home managers knowledge of palliative care and found that some managers need to improve their knowledge and competence in this area

Staff commented that they experienced increased knowledge and awareness of end of life care 'I thought as soon as you said Palliative Care I'd say you've only got X amount of time to live and she said no you could be on Palliative Care for years.

Participants appreciated the level of training and support that the hospice staff bought, considering some of their knowledge transfer as 'little nuggets of gold...oh I'll remember that' (Grp2).

Four care home staff focus groups were undertaken comprising 26 attendees in 4 locations across Rotherham and one Hospice staff focus group. The focus groups consisted of staff who had received the training, or used the telephone helpline, or the bespoke support, or a combination of all three.

Hospice at home staff have been visible and present when care home staff needed their support.

Additionally, the care staff's knowledge and confidence in managing palliative and end of life care has been shown to have improved, and subsequently the experience of the patients and families involved

Data suggests that the increased knowledge and confidence brought about by the training package, timely advice and bespoke support has led to an increase in positive decision making.

Between October 2017 and September 2018 a total of 388 admissions and 119 GP visits were reportedly avoided through the team's input to care homes.

Staff felt the training enabled them to adopt a more person centred perspective, to 'give people the view of that person as a whole, complete with the families to get it' (Grp2). They appreciated the training being tailored to meet the needs of the care home staff

A perceived increase and confidence in knowledge around the context of dying also enabled staff to be more confident when talking to families about end of life care. 'I think it's made people think, I think it's opened people's eyes so I think people are feeling more comfortable about having those conversations' (Grp1).

The participants discussed how much more efficient it was to liaise with the hospice staff than GPs '...With most other professionals, with Doctors and that, you have to go through the scenario all over again. Tell them about the patient, about this, about that, but no, they've already got that information. Even if they've already seen them, if it's somebody new they've got that information, it's already there so you're not having to go through it' (Grp2).

Participants appreciated the improved level of coordination that came from the pilot service in that they experienced better continuity of care as well as how proactive support was. They felt this was because of the training as it had led them to have better relationships with the hospice as well as the hospice being 'closer' to the care home.

For some places bespoke, in-house training had been more useful and others preferred to be able to plan and rota staff to attend the hospice based training. '... sometimes people do prefer training in house rather than having to travel somewhere to do training? ...if it's in-house, you do sometimes find more people will come.(Grp2)

In relation to advanced care planning there were no direct observations by the participants regarding their increase in use but there was a sense of a change in practice. For example in Group 1 comments indicated change was 'Massive, it opens your eyes up to so many things