Training in care homes to reduce avoidable harm

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Training in care homes

Norman Lamb, the minister of state for care and support, recently stated that the lack of basic requirements for training healthcare assistants was leaving frail older people in the hands of staff who have “no idea what they are doing” (Ross, 2013).

After the Francis report, pressure on care homes to improve standards is increasing, with carers undergoing compulsory training in areas such as washing and dressing. The Care Quality Commission is considering how to monitor the number of deaths in care homes, adding to the pressure they are under to provide high-quality training to unqualified care staff (Ramesh, 2013). A more robust training schedule would be likely to not only improve patient experiences but also reduce the number of avoidable hospital admissions (McNicoll, 2012).

With this in mind, we developed an education and support model tailored to care homes. Our goal was to work in partnership with community matrons to reduce hospitalisation from care homes by providing training to unqualified staff that increases awareness and builds on existing knowledge in three key areas:

- Prevention of falls;
- Prevention of grade 2-4 pressure ulcers;
- Continence promotion, including the prevention of urinary tract infections and the correct use of continence products.

By the end of the training, we expected staff to be confident in assessing risk and writing prevention care plans, and to be aware of which health professional to refer to. We then worked with the care homes to develop service improvement models to advance the care delivered, allowing staff...
to manage their working day more efficiently. We managed this by developing new assessment charts and introducing intention rounding.

Project goals
Each home was set the following reduction targets:

- Falls – 40%
- Recurrent falls – 60%
- Care home-acquired grade 2 pressure ulcers – 75%
- Care home-acquired grade 3 and 4 pressure ulcers – 95%
- Urinary and catheter-acquired infections – 40%
- Hospital admissions – 60%
- District nurse visits – 40%
- GP visits – 40%

Once these targets had been reached, we aimed to sustain these levels through continuing to work with the care homes.

Care home recruitment
When we first approached care home managers and owners, they were generally sceptical about the project. The general belief was that it was a paperwork exercise by the trust or a response to alleged poor care. The majority of homes wanted a long-term commitment from the community trust before they committed fully. Once this had been assured, the recruitment process continued without issue and we were able to recruit two homes a month out of the 47 for which the project was commissioned.

We approached each home six weeks before it was due to join the project. Meetings were arranged to discuss all aspects of the project and the start date was agreed. This could take up to four meetings as it was important to ensure that the manager, staff and company operating the home were all fully on board.

Data collection
Before any training could take place, targets were set that homes would aim to meet. We asked each home to provide the following information each month:

- Total number of falls, including multiple (recurrent) falls by the same patient
- Total number of urinary and catheter-acquired infections
- Total number of grade 2, 3 and 4 pressure ulcers
- Total number of hospital admissions

The local district nursing team and GP surgery reported monthly on the number of extra calls made to the home (extra calls are calls that have not been referred or are on the caseload at that time). Out-of-hours GP services also provided us with the number of calls to the home in that month.

We collected this data for three months before the training started to provide us with average monthly episode figures. It was then collected monthly so change could be measured.

Training packs
Using local and government policies for guidance, three workshop-based training packs were developed. These were based around early recognition of presenting symptoms, early risk assessment and improving referrals (Box 1).

We aimed to improve knowledge and give staff the confidence to take the lead in providing care. By assessing risk early, response times can be reduced and the correct equipment used to prevent further deterioration and improve general care.

Sustainability
Each home received a two-hour support visit each month. Its purpose was to:

- Support staff and management
- Work with the home to develop and instigate new ways of working
- Act as a link between the care home and health services
- Offer support with instances of unsafe or poor discharge from hospital
- Assist and support inter-team liaison
- Encourage staff to take the lead on service improvement projects
- Develop and audit new assessment and referral charts to improve communication and care provision

Results
The project achieved the results below over its first year.

Home visits
Visits to the homes by district nurses and GPs fell by 60% (Fig 1).

Falls
There was a 63% reduction in falls and a 75% reduction in recurrent falls (Fig 2).

Pressure ulcers
Care home-acquired grade 2 pressure ulcers were reduced by 63% and grade 3 and 4 by 88% (Fig 3).

Urinary tract and catheter-acquired infections
The project reduced UTIs by 66%; teaching the staff to dip test urine samples reduced
the number of urine samples sent for analysis by 74%.

Hospital admissions
The number of care home residents admitted to hospital fell by 51%.

Conclusion
Through a robust training package and tailored support, we have been able to reduce the number of avoidable hospital admissions from participating care homes by 51%. By raising awareness of symptoms and encouraging early risk assessment and care planning, we have also raised the level of care delivered to vulnerable patients.

Plans
We are recruiting two care homes per month until we have trained all 47 care homes in the project. We then hope to extend it into other areas in Lincolnshire, depending on funding.

We have demonstrated a significant link between falls and UTIs. Early assessment by care staff, including recognition of symptoms and urine dip test results, has reduced the number of recurrent falls in care homes. However, we have found it still takes a long time for antibiotics to be started and are working on a pilot project with GP surgeries, care homes, out-of-hours GP services and community matrons to reduce this time for patients who are susceptible to recurrent UTIs.

To ensure long-term sustainability, we aim to establish link nurses within the homes. These will work on a “train the trainer” basis and will be supported by the community teams to deliver top-up training every two years. We will also be running yearly conferences in Lincolnshire aimed at care and nursing homes. The three-monthly steering group meetings will continue alongside the monthly two-hour support visits.

We are also working on creating links with local social services and universities. By linking in with the safeguarding team, care homes experiencing difficulties can receive help to work through issues. Student nurses are being encouraged to teach the 6Cs in care homes (Cummings and Bennett, 2012), giving the next generation of nurses the opportunity to incorporate teaching and partnership working into their curriculum and raising their awareness of nursing in care homes.

We are looking at managing recurrent UTIs by working with community matrons to develop an innovative assessment and referral method that will result in quicker administration of antibiotics in care homes. NT

References
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Fig 1. HOME VISITS
Fig 2. FALLS
Fig 3. PRESSURE ULCERS
Fig 4. URINARY TRACT INFECTIONS