Practice development in end of life home care

Dr Stephen J. O'Connor
Reader (Associate Professor) in End of Life Care,
School of Nursing and England Centre for Practice Development,
Canterbury Christ Church University,
Canterbury, UK.

Adjunct Professor of Nursing,
State University of New York at Buffalo,
Buffalo, USA.

stephen.oconnor@canterbury.ac.uk

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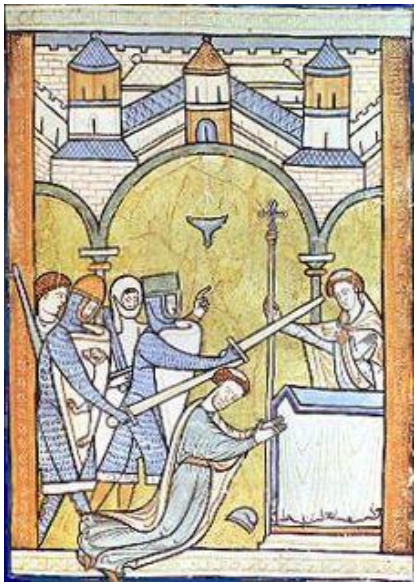

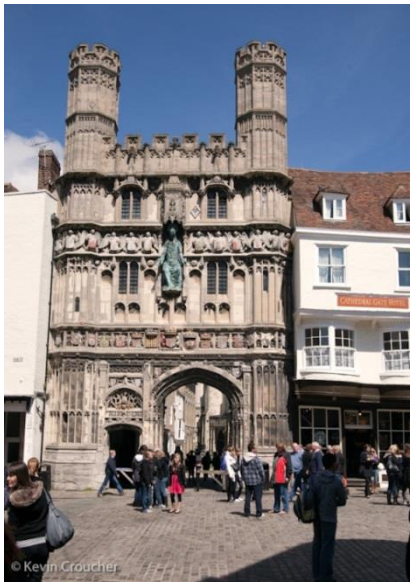

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What is practice development?

'Practice development is a continuous process of developing person-centred cultures. It is enabled by facilitators who authentically engage with individuals and teams to blend personal qualities and creative imagination with practice skills and practice wisdom. The learning that occurs brings about transformations of individual and team practices… This is sustained by embedding both processes and outcomes in corporate strategy'.

(International Practice Development Colloquium, cited in Manley et al., 2008, p9)

What does practice development aim to do?

- Elicit cultural change to create safe, effective workplace cultures.
- Stimulate care which is person-centred and evidence-based, yet is flexible enough to adapt to changing needs and contexts.
- Identify and address internal and external barriers to change through systematic critique, appreciative inquiry, structured reflection, debate and contestation of reified values and practices.
- Collect and evaluate different types of evidence to develop an understanding of workplace culture.
- The resulting framework should inform the facilitation of effective cultural and/or organisational change.

Why do we need practice development?

- Contemporary healthcare outcomes fall broadly into the domains of safety, effectiveness, and patient experience (DOH, 2010).
- Recent well-publicised failures in care in the UK were attributed to poor workplace cultures and a lack of person-centredness, as well as an unwillingness to question the values and behaviours inherent in those cultures (Mid Staffordshire NHS Foundation Trust Inquiry, 2010; Patients Association, 2009).
- Improvements in workplace culture are positively correlated with improvements in staff experience, wellbeing and commitment, which in turn impact on patient experience and clinical outcomes (NHS National Institute of Innovation, 2010; West et al., 2006).

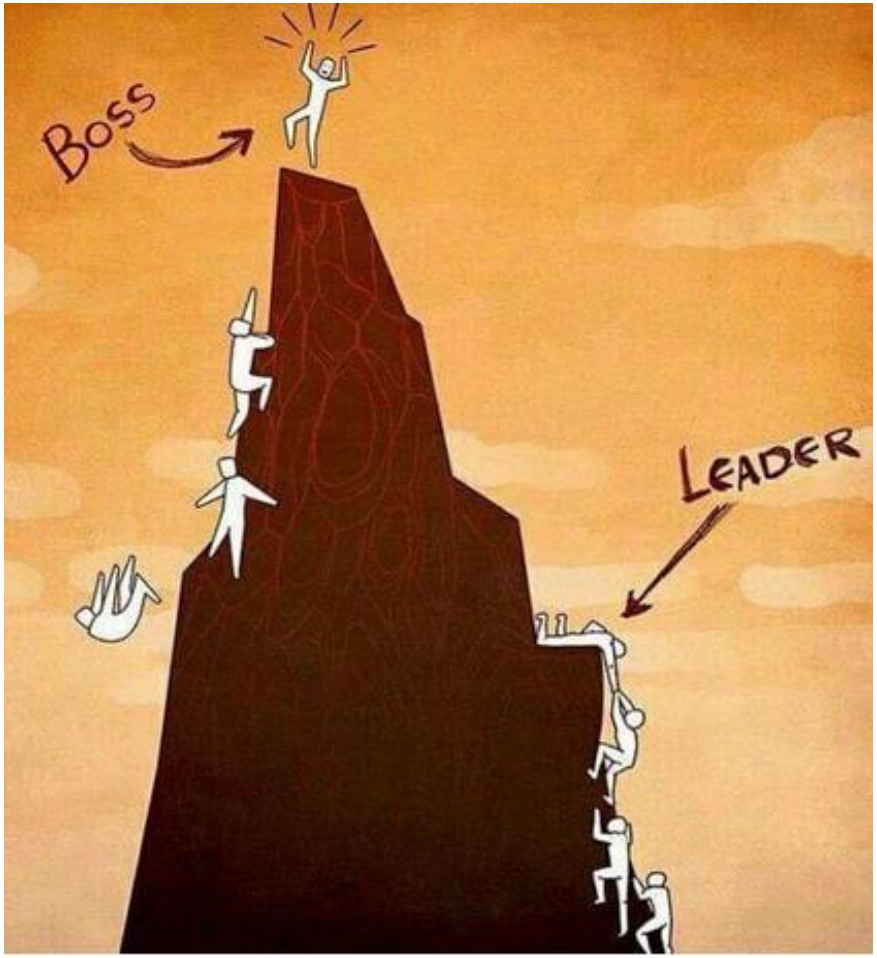
What are the aims of practice development?

- Continuous quality improvement.
- Improved person-centred care.
- The development of effective workplace cultures.
- It seeks to achieve this by:
  - facilitated approaches to practice improvement
  - development of team effectiveness and new ways of working
  - developing clinical governance and personal accountability in all members of the team as part of everyday practice
  - evaluation of changes in workplace cultures and contexts
  - development of leadership attributes and skills

Clinical leadership is key

- emergent leadership
- authentic leadership
- facilitative leadership
- responsive leadership
- shared (or distributed) leadership
- servant leadership

= transformed workplaces



The six deliverables of practice development

- Placing the individuals' needs at the centre of care.
- Involving patients and clients in decision-making and changes to service delivery.
- Developing systems and cultures capable of delivering safe, competent and effective care.
- Enabling staff to develop new ways of working.
- Facilitating the development of evidence-based practice (and practice-based evidence).
- Systematic cultural and/or organisational change which is amenable to measurement and evaluation.

(Manley et al., 2009)

How does safety fit into practice development?

- Safety is regarded as an outcome which is ***valued*** by everyone in the organisation rather than simply ***complied*** with (Clark, 2002).
- Safety embraces physical, psychological and social aspects of care - not just for patients/service users and their families, but for staff as well (Clark, 2002; Groah and Butler, 2006).
- This is reflected in a commitment to:
  - reduce adverse events for patients (Bhatia et al., 2003)
  - foster prevention strategies (Schneider et al., 2003)
  - be honest about mistakes when they occur (Hart and Hazelgrove, 2001; Clark, 2002; Kalish and Aebersold, 2006)
  - identify and manage risk as part of the job (Cox et al., 2006; Scalzi et al., 2006).

Attributes of practice development projects

- Working ‘with’ people rather than ‘on’ them in ways that encourage collaboration, participation and empowerment.
- Agreeing values and beliefs about what is to be achieved and ways of working, and support for agreed behaviours before starting.
- Involving everyone in decision-making, encouraging joint responsibility and respect for different perspectives throughout the process.
- Using the best evidence available blended with particular knowledge of the patient (or context) to deliver safe, effective care.
- Promoting a continuous cycle of practice/service/quality improvement, adaptation, innovation and the development of practice-based evidence.
- Embedding shared values and beliefs and related patterns of behaviour into the workplace culture by developing social systems that reduce dependence on specific individuals.

Some methods used in practice development

- Various methodologies are used – depending on the solution being sought, the context of care and individual workplace cultures but include:
  - participatory/emancipatory action research
  - appreciative enquiry
  - critical enquiry
  - peer evaluation
  - values clarification
  - root cause analyses of the things that go wrong
  - development of shared purpose frameworks

What is shared purpose?

- Underpinning the NHS Shared Purpose Model (NHS, 2013),

'Shared purpose results when a group of individuals aligns their belief systems or values with a common challenge, vision or goal.'

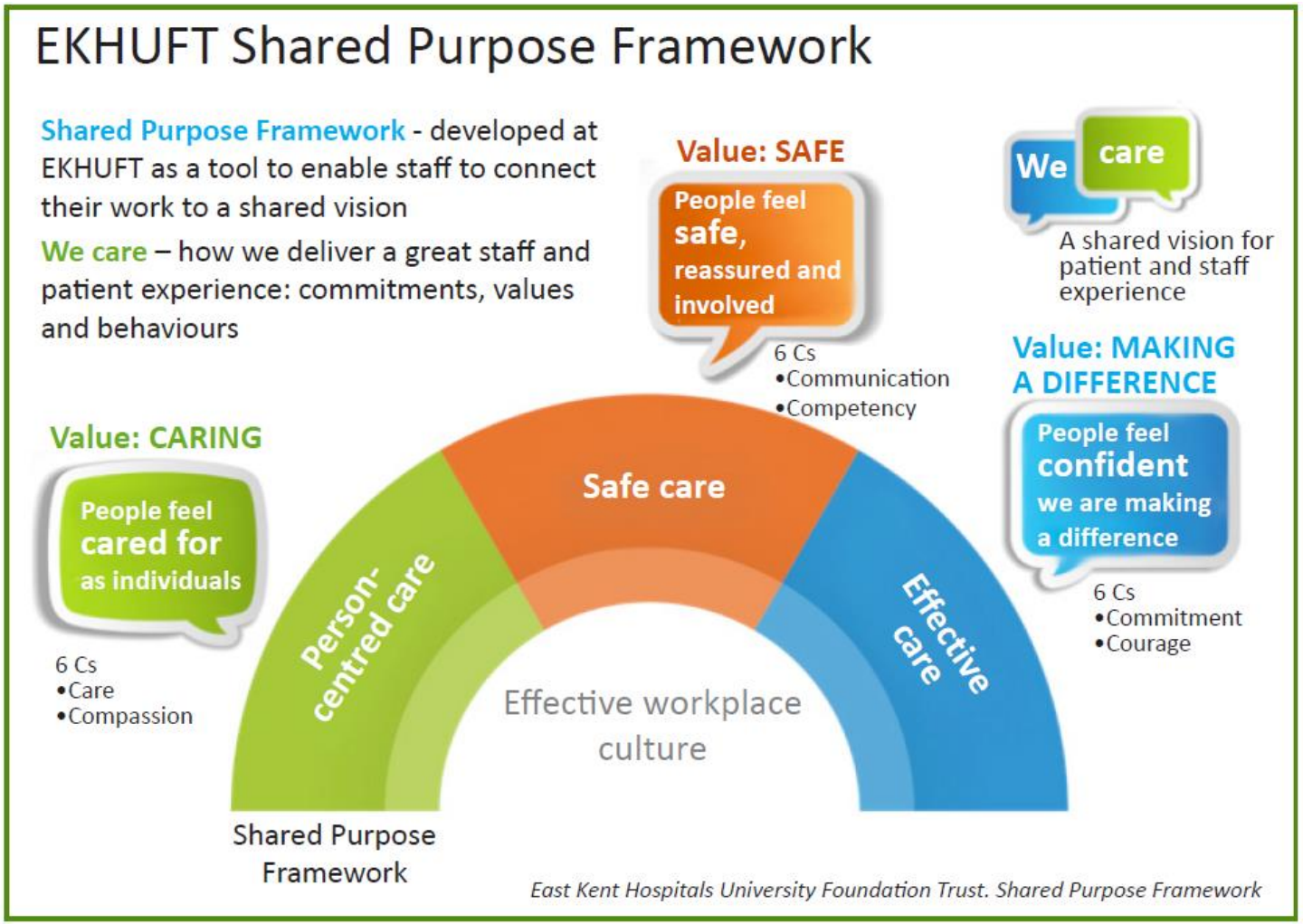
(Finney, 2013, p 5).

What is shared purpose?

'Purpose taps into people's need for meaningful work; to be part of something bigger than ourselves. It encapsulates people's cognitive, emotional and spiritual commitment to a cause. It becomes shared when we find commonalities between our values, beliefs and aspirations.'

(Finney, 2013 p6.)

The importance of shared purpose frameworks



(Manley et al, 2014)

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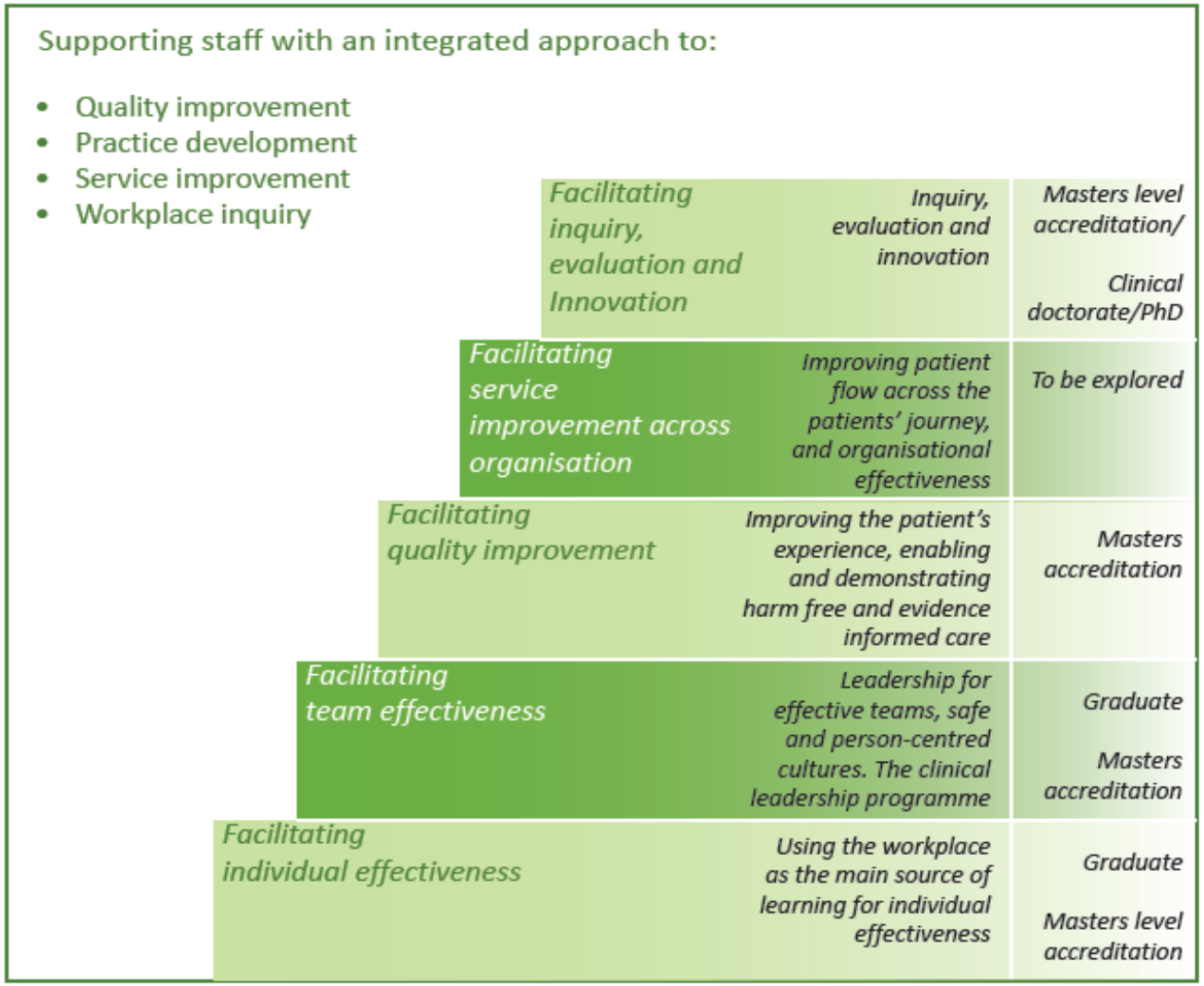
EKUHT shared purpose framework sub-themes

Person-centredness	• Providing person-centred compassionate care • Courageously speaking up for and listening to patients • Inviting and using patient and service user feedback • Working in a person-centred way with others
Safe care	• Providing safe care • Embedding the safety culture • Reviewing and improving safety practice
Effective care	• Providing effective care to individuals and groups • Maintaining one's own effectiveness and enabling others to be effective • Evaluating and researching effectiveness
Effective workplace culture	• Being self-aware and developing effective relationships • Working as an effective team • Leading person-centred, compassionate, safe and effective care • Active learning for transforming care and practice • Developing, improving and innovating

EKUHT strategy for workforce development



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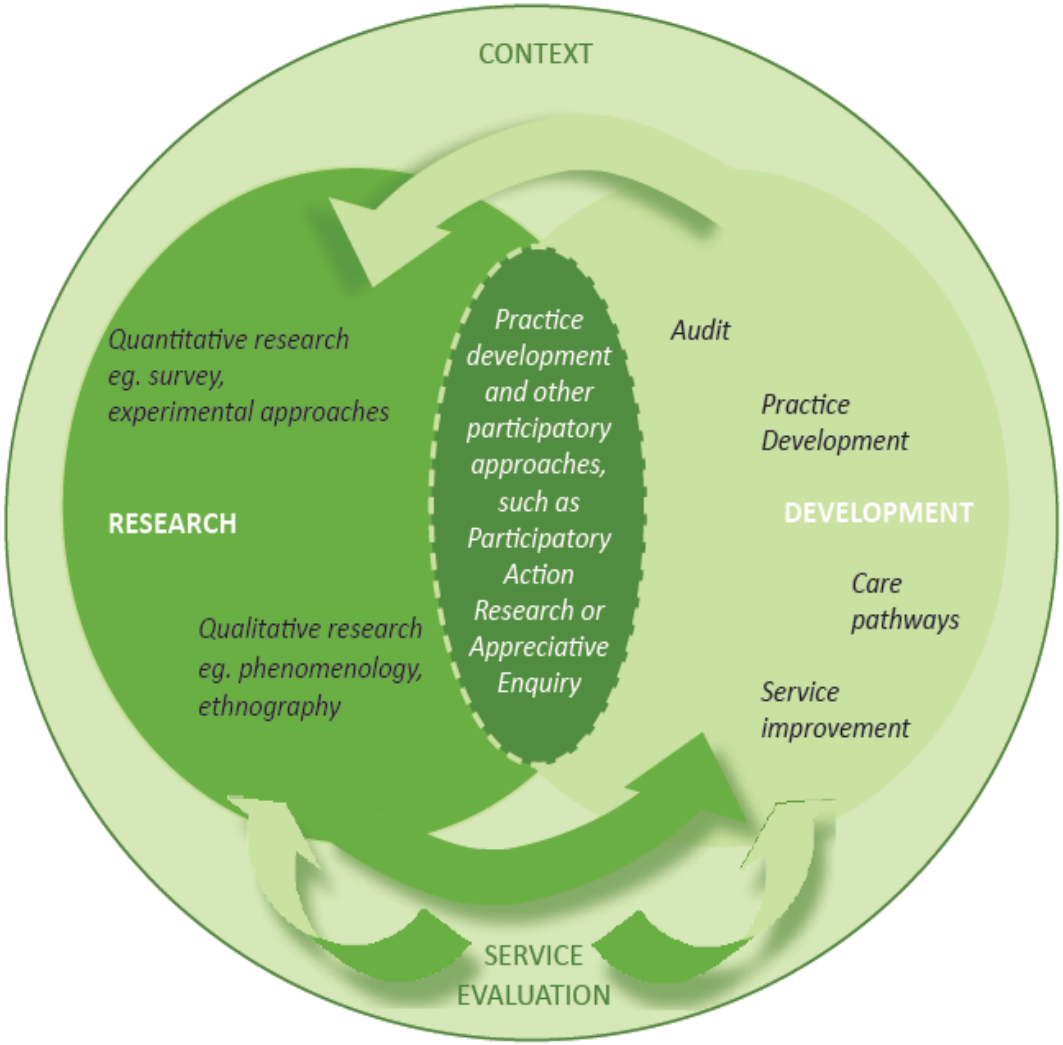
How does PD differ from other research?

- Practice development's main intent is transformation of individuals, teams, practices, and cultures to create safe, effective and sustainable workplaces.
- The focus is explicitly on people and cultures and not on specific patient problems or interventions.
- It uses active, work-based learning and learning organisations theory to achieve a *'plurality of outcomes'* that can be applied anywhere (Harvey et al., 2002; Rycroft-Malone et al., 2002a, 2002b, 2004a, 2004b).
- Therefore described as a 'a complex intervention' which can be adapted and applied to different settings (MRC, 2006).

Spanning the theory-practice and R&D gaps



(Central Nursing Advisory Committee of Northern Ireland, 2012)

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A study to reduce healthcare acquired infections in housebound clients

- The term ‘health care associated infection’ was defined as any infection acquired as a consequence of a person’s treatment by a healthcare professional or acquired by a carer in the course of their professional duties.
- The project took an ‘evidence based design’ approach which *‘captures the experiences of clients and identifies ways to improve them’* (NHS Institute for Innovation and Improvement, 2009) and included:
  - investigation of house-bound clients’ views about infection risk and ways to improve satisfaction / staff adherence to guidelines on infection control etc.
  - identification of measures to reduce infection risk in clients’ homes in order to reduce and control incidences of infection

A study to reduce healthcare acquired infections in housebound clients

- development and implementation of management systems and procedures for infection prevention and control for house-bound clients
- worked closely with the adult nursing teams to support house-bound clients and raise confidence in the infection control service
- produce client information on managing infection control in the community and raise knowledge and support practice
- deliver high quality, evidence-based care in infection control practice

Supporting vulnerable patients at home

- Brant et al (2012) sought to define who 'vulnerable' patients were and how they could be supported in the local community. It included:
  - values clarification exercise about the aims of any new service
  - consultation as to what on-going support systems might be necessary with staff asking:
    1. *What kind of person is it that might require support?*
    2. *Who else might already be involved in their care?*
    3. *How can we (in General Practice) support them?*
    4. *How can we identify them*
  - development of a home visit template to assess four identified problems: referral and support needs, depression risk, clinical care needs and medication needs.

Supporting vulnerable patients at home

- awareness raising activities about ‘vulnerable’ patients and their needs
- development of a simple assessment too for GPs, practice nurses and community nurses to assess patients on each visit
- identified patients placed on a ‘vulnerable patients register’ to be discussed at 3 monthly meetings
- nursing team to review patients on the register more formally on an annual basis prior to the flu season
- a shorter template developed to be taken and completed during each home visits based on the target areas: depression, help and support at home, medications and clinical assessment.

A project to improve drug safety at home

- Kelly et al. (2013) - triggered by a drug administration incident following discharge of a patient from a private central London hospital.
- The aim was to improve the management of medicines for older people on discharge from hospital by engaging with the relatives, staff, patients and wider stakeholders to redesign the take home medication chart.
- Redesign was been achieved and staff training initiated after consultation with staff and older patients about the information they needed.

A project to improve drug safety at home

The practice development project included:

- informal staff dialogue and reflection on the trigger event
- engagement with patients and members of the medication committee
- engagement with community stakeholders (e.g. GPs and community nurses etc.) to understand the issues from their side
- involvement of all stakeholders in redesigning and implementing the new take home medication chart
- values clarification exercise and creation of shared values poster
- staff awareness raising and an education event
- evaluation of the effectiveness of the redesigned chart for patients
- critical analysis and feedback from staff regarding the new chart.

Practice development in palliative/EOLC

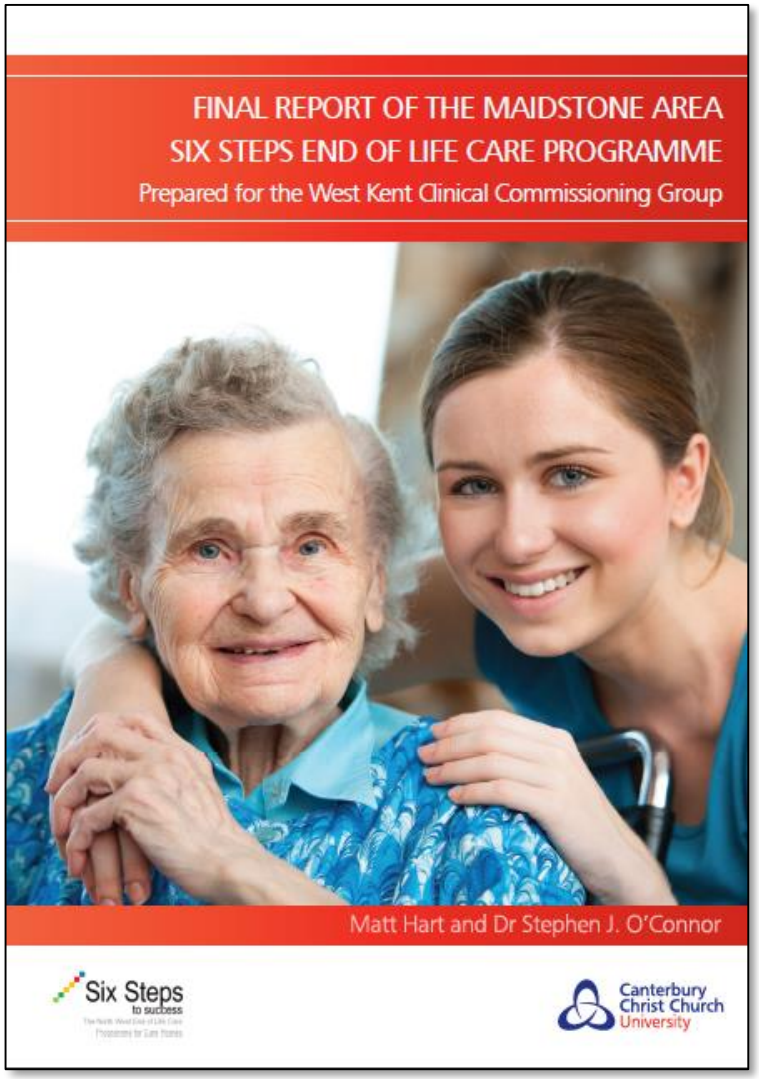
- In the UK, service delivery models for palliative homecare vary from teams that only provide crisis interventions (rapid response teams) through respite and sitting services, to direct delivery of 'hands on' care.
- The remit, composition, and leadership of palliative homecare teams/services also vary.
- Studies exploring end of life care at home have identified multiple factors that impact upon whether a good home death can be achieved - including the amount of support available, patient and family preferences, and the ability of carers to cope at home (Gomes and Higginson, 2006; Caress et al., 2009; Jack and O'Brien, 2010; Baldry et al, 2011)

A project to deliver effective EOLC at home

- Baldry et al. (2011) undertook this project to meet an identified shortfall in end of life care provision in the home. It included:
  - values clarification and consultation exercise with all stakeholders to find out exactly what services were already available in the locality and the gaps in current services
  - critical enquiry to assess whether the hospice was the right service to fill identified gaps in service provision
  - evaluate whether the necessary clinical leadership was available to deliver the service – and was fully cognisant with the district nursing service and how it works
  - recruitment strategy to ensure that all staff had either community nursing experience or palliative/EOLC experience - or both.

The Six Steps Project

- Values clarification about what is important in caring for the dying.
- Delivery of training to upskill homecare staff in end of life and communication skills.
- Development of new policies and processes to manage dying in the care home including.
- Liaison with GPs, ambulance services, local hospitals, nursing homes and community nurses caring for residents.
- Stringent evaluation to pre-determined outcome measures.



Critical incident analysis of deaths (n=91)

ID	Cause of death	On an end of life care register Y/N	Advance Care Plan in place Y/N	Preferred place of care if known	DNACPR in place	Out of Hours Handover completed	EOLC prescribing in place	Resident died on LCP	Number of non-elective admissions in last year	Reasons for admissions	Place of Death
1	CA Bowel	N	N	CH	Y	N	Y	N	1	Abdominal pain	CH
2	?	N	N	CH	Y	N	Y	N	0	?	CH
3	Old age	N	N	CH	Y	N	Y	N	1	Blood transfusion	CH
4	Sudden cardiac	N	N	CH	Y	N	N	N	2	Vagal bleed	CH
5	Fall/fractured hip	N	N	CH	Y	N	Y	N	1	Fall/fractured hip	CH
6	Sudden Cardiac	N	N	CH	N	N	N	N	0	?	CH
7	Old Age	N	N	CH	Y	N	Y	N	0	?	CH
8	Old age	N	N	CH	Y	N	Y	N	2	Fall and cuts	CH
9	Cardiac	N	N	CH	Y	N	N	N	1	Dehydration	Hospital
10	Old age	N	N	CH	Y	N	N	N	0	?	CH
11	Chest infection	N	N	CH	Y	N	N	N	0	?	CH
12	Deterioration	N	N	CH	Y	N	y	N	0	?	CH
13	Chronic Heart Failure	N	N	CH	N	N	N	N	0	?	CH
14	Deterioration	N	N	CH	Y	N	N	N	0	?	CH

Care Home	Thistle Lodge NH	Rose Lodge RCH	Azalea Lodge RCH	Petunia Lodge RCH	Clematis Lodge RCH	Daffodil Lodge RCH	Crocus Lodge SH	Gerbera Lodge SH	Tulip Lodge CH	Freesia Lodge RCH	Iris Lodge CH	Lobelia Lodge RCH
Pre programme: post death audit	X	X	X	X	X	X	X	X	X	X	X	X
Post programme: post death audit	X	X	X	X	X	X	X	X	X	X	X	X
Pre programme: CH Audit	X	X	X	X	X	X	X	X	X	X	X	X
Post programme: CH audit	X	X		X	X	X				X	X	X
End of life care policy	X	X	X	X	X	X				X	X	X
End of life care coding	X	X		X	X	X				X	X	X
End of life care register	X	X		X	X	X				X	X	X
System for advance care planning	X	X	X	X	X	X						X
System for holistic assessment	X	X		X	X	X						X
Out of hours handover												
Discussion meeting with GP(s)	X	X		X	X					X	X	X
System for regular review with GP(s)	X	X	X	X	X					X	X	X
Key worker system in place		X		X	X	X			X	X	X	X
Services network information	X	X		X	X	X				X		X
Training needs analysis	X	X		X	X	X						X
System for reviewing all transfer of residents	X	X		X	X	X			X	X	X	X
Significant event analysis	X	X		X	X	X					X	X
Facilities leaflet, after death leaflet	X	X		X	X	X				X		X
On-going post death audit	X	X	X	X	X	X	X	X	X	X	X	X

Measuring and embedding cultural and organisational change

- against multiple, pre-determined quality and safety indicators with assessment at baseline, throughout and after the process (at 3, 12 and shortly; 18 months).

(Some interim progress data depicted)

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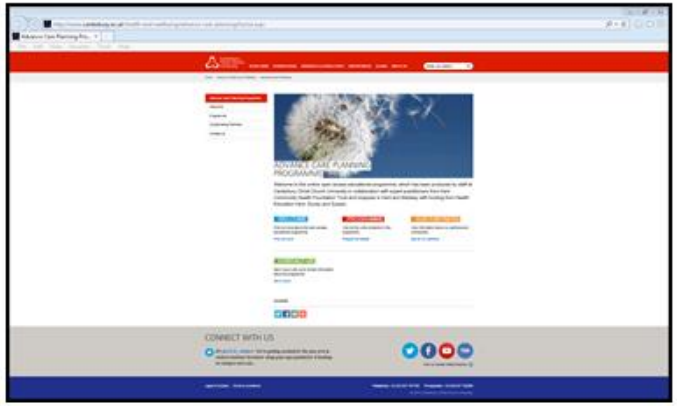
Technology Enhanced Advance Care Planning

- An NHS funded practice development intervention to improve advance care planning by all health and social care staff in SE England.
- Educational materials developed collaboratively after a values clarification exercise by hospices and healthcare providers in the area.
- Quality controlled to academic and funder specifications and end-user pilot evaluation in one health trust.
- Being launched nationally on the NHS training platform this year.



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