

*Care Home Support Team, working in partnership with Homes
and other agencies*

CARE HOMES SUPPORT TEAM, EVALUATION OF WORK SO FAR

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SUMMARY OF CARE HOME SUPPORT TEAM WORK

Background

The Care Home Support Team was developed in response to an acknowledgement of the inadequate and fragmented support to Care Homes from the Health Community, which historically has led to the sense that "Independent Care" is 'private care' and outside the main health community. However, the PCT is responsible for the health and well-being of everyone living in their area.

The team aimed to reach a much better understanding of the existing problems in the quality of care being delivered in our Care Homes, and develop solutions which would improve the care, and re-integrate Care Homes into the mainstream.

Staff resources on the project team

The Care Home Support Team (CHST) employs two full time nurses, a Pharmacist for three days a week (0.6WTE) and has input from two GPs. The CHST works with 48 Care Homes for Older People in the West Glos PCT area, this includes both nursing and residential provision of care.

Main areas of work

The CHST have worked with Homes on many different projects which have all developed as solutions to identified needs:

• Communication with Care Homes

The CHST have developed strong links with Homes, initially this involved undertaking work to introduce the idea of a Support team and to try to identify what needs there were in the Homes. The Team decided to focus on a small number of homes at a time and work intensively with them and then move on to another group, while still being available to help all Homes.

As the Homes have become more aware of the role of the CHST nurses and have understood the benefit of involvement, the communication has increased and by the end of the second year the majority of Care Homes will regularly contact the team for advice on clinical issues, training and as a contact resource.

• Active Ageing programme (Falls prevention)

From the initial communication work it was found that falls were a common reason for hospital admission from homes, for this reason a falls prevention project was developed. The team's Active ageing programme won a national Queen's Nursing Institute Award for the training and improvement in Falls Prevention work in Care Homes. This enabled the team to train staff, both theoretically and practically, to become competent in delivering individualised exercise programmes within their Care home environment.

• Training for Care Home staff

A very key area of work has been to identify the training needs of staff in Care Homes. A huge range of standards in client care has been observed, and it is clear that until training on the basic care is established, staff will not be able to take on enhanced roles. It has been identified that Care Home staff are not always able to access training and that the staff often feel very isolated from other healthcare professionals. The CHST has focused on helping to reduce the training gap by improving access to training and by running many training sessions both in-house and on a larger scale.

• Improvements in management of palliative care in Care Homes

Another key area that was identified was support for Care Homes is in the provision and knowledge of palliative care. The aim is for Care Home nurses to develop the skills and have support from the CHST to enable their clients to receive appropriate end of life care in their preferred place of care as opposed to needing the hospital setting. Much work has been done to improve support for Homes in this area, including a rotational training post for Care Homes Nurses at a local hospice, introduction of the Countywide palliative care pathway, and improvements in access to syringe drivers and training on how to use these within the Homes.

• Policies and paperwork

Care Homes need to provide client-centred care and must implement a preventative approach including active surveillance and early intervention at the first signs of deterioration. The benefit of standardised assessment tools and good quality assessment of clients is well documented in published evidence, and both Social Services and CSCI recognise this as a current failing of many Homes. The CHST has worked to develop and implement some standard paperwork, and as well as providing the Homes with this paperwork, the Team have trained staff on the use of the paperwork, and regularly reviewed the progress which has increased the success of its implementation.

• Medication reviews

Medication reviews for clients in the Care Homes have been an important part of the team's work and have produced vital feedback and communication links with all GP surgeries as well as cost savings and an improvement in prescribing for Care Home clients. If the pharmacist is working 3 days a week it is estimated that they would review 1000 clients in 12 months, and save in excess of £79,000.

• Supply of client's medical information summaries to the Care Homes

One identified communication gap was the limited medical information the Homes had access to for their clients, following this the CHST developed a system for Homes to keep a copy of each client's medical summary from their GP. This now enables the Home to be fully informed when providing care, and also provides information for out of hours medical care.

• Rationalisation of provision of Medical services to Care Homes

Following the identification of the perception that better medical care exists where Homes have a good working relationship with a few GP surgeries, the CHST have undertaken to rationalise the provision of medical care to Care Homes from GPs to try to reduce the number of GP Surgeries each Home works with.

• Caseload management of complex clients in Care Homes

Following referrals from Homes, district nurses and specialist nurses, the CHST nurses have begun to develop a caseload of clients with especially complex needs. For these clients the CHST have provided in-depth assessments, hands on care and training and support for the Care Home staff. This has already resulted in improvements in care and avoidance of hospital admission; this is an area of work which will hopefully develop in the future.

• Liaison with specialist nursing resources

The CHST nurses have established collaboration with Specialist Nurses in specific disease areas. Not only has this allowed Care Homes access to the knowledge of these nurses, it has also established that these nurses feel unable to respond to the potential demand within the Care Homes, and feel that Care Home specialist nurses are more appropriate.

A commonly used approach is for the CHST nurses to update their own knowledge through contact with these nurses and for them to disseminate the information during in-house training sessions in the Homes.

• Work on a policy for advance directives and Do Not Resuscitate guidelines for clients in Care Homes

It has been widely observed that Care Homes do not always have the appropriate support in helping their residents make decisions at the end of their lives. Without fully documented and agreed decisions this can result in traumatic and unwanted hospital admissions and treatment. The CHST, in collaboration with many parties, have been involved in developing a policy on advance directives and DNAR decision making in Care Homes and the Community.

CARE HOMES SUPPORT TEAM, EVALUATION OF WORK SO FAR

1.0 Background to Care Home Support Project

- 1.1 The Care Home Support Project was financed by a project grant from Social Services Access and Capacity Grant in 2003/4. The project commenced September 2003, and was initially expected to run for two years.
- 1.2 The Project was set up as an acknowledgement of the inadequate and fragmented support to Care Homes from the Health Community, which historically has led to the sense that "Independent Care" is 'private care' and outside the main health community. However, the PCT is responsible for the health and well-being of everyone living in their area.
- 1.3 The Project aimed to reach a much better understanding of the existing problems in the quality of care being delivered in our Care Homes, and develop solutions which would improve the care, and re-integrate Care Homes into the mainstream. It was anticipated that this would include developing policies for care, providing on-site training, and focus on issues such as end-of-life care. The project is being used to help advise on long-term solutions to sustain improved quality of care.
- 1.4 The Team work with 48 Care Homes for Older People in the West Glos PCT area.

2.0 Staff resources on the project team

- 2.1 The Care Home Support Team (CHST) employs two full-time nurses who are the backbone to the project.
- 2.2 For the first 18 months, two GP's were employed for a session a week each, and were found to provide a crucial link to West Gloucestershire GP's, to test ideas, explore scope for change etc. Due to funding issues this involvement was decreased in September 2005 to one session a month from one GP.
- 2.3 A pharmacist has been employed for 3 days a week since August 2004.
- 2.4 The team was initially supported managerially by Lesley Dibben, which has now passed to Helen Bown. The team has overall project leadership from Dr Ian Donald.

3.0 Main areas of work

3.1 Communication with Care Homes

During the first year, the team made contact with all 48 Care Homes, and experienced a range of responses, from open arms to lukewarm. Unfortunately a number of the Homes which most need help were found to be unenthusiastic, and this seemed to depend upon the manager's attitude.

One important initial piece of work was to meet with all the Homes and undertake an audit to identify areas of support required by Care Homes and to identify training needs. The CHST GPs undertook to visit all Care homes involved with the team and spent time discussing the issues that the Home staff felt they would benefit from support with and areas that they often had problems with. Several common themes emerged and it was clear that different issues were raised in these discussions in comparison with visits from the nurses and the audit. All of this produced key areas for the team to focus on.

As the Homes have become more aware of the role of the CHST nurses and have understood the benefit of involvement, by the end of the second year the majority of Care Homes are contacting the team for advice on clinical issues, training and as a contact resource.

During the second year of work the team decided that it would be of greater benefit to work with a small number of Homes at a time and concentrate the whole team's efforts on

these Homes and then share the experience to all Homes. This has been very successful and has allowed to team to set up systems for focusing on a manageable number of Homes at a time while still providing all Homes with contact.

3.2 Active ageing programme (falls prevention)

The initial CHST audit of Care Homes in 2004 showed that the major reason for admission to hospital was falls. Falls have a huge impact on the welfare of clients and there are huge costs involved in treating fractures and other complications of falls. In order to act on this and prevent falls in care homes the CHST developed the County-Wide falls risk screening tool for use in Care Homes in partnership with the Falls Liaison Officer at Gloucestershire Royal Hospital. At a recent Countywide falls Team meeting it was acknowledged that the CHST had been the only area successful in implementing the Falls Prevention Tool.

Closely linked with this screening tool, the CHST was involved in producing a falls prevention programme called the Active ageing programme. This initiative won an award from the Queens Nursing Institute which has enabled the team to train staff, both theoretically and practically, to become competent in delivering individualised exercise programmes within their Care home environment.

The first cohort of care home staff have qualified as SAFE practitioners, and are delivering exercise sessions on a weekly basis in their Care Homes.

The second cohort of staff from 10 homes is now undergoing their theoretical and practical training.

Total participation in this is 10 dual registered homes, 3, EMI Nursing Homes and 4 Residential Homes.

Future work for the active ageing programme

- To review clients 6 months after the initial screening, collate the evidence and audit the results.
- Other PCTs and agencies nationwide have expressed an interest in the project therefore production of a training pack is required.
- Pilot a training scheme to train staff in a higher level of exercise, with a more ambulant client group.
- Maintain the sustainability by offering networking and update sessions to SAFE Practitioners.
- Seek additional funding to take Active Ageing into all Care homes of West Glos PCT.

3.3 Training for Care Home staff

Through the work of the CHST, the training needs of staff in Care Homes have become much clearer. It has become obvious that there exists a huge number of staff who do not have access to appropriate training and updates and therefore often feel quite isolated and deskilled. If Care Home staff are not able to provide good quality basic care for clients then the types of patients who can be managed successfully in long term care will be limited.

Although training opportunities do exist (for example, the Workforce Confederation provides support for NVQ training for Care assistants in Homes, but not trained staff), many Care Homes are reluctant to release staff for training and provide backfill, and many training courses run in the county seem to exclude staff from the Independent Sector.

A huge range of standards has been observed, and it is clear that until the basic care is established, staff will not be able to take on enhanced roles; therefore the CHST will continue to push for trained staff to be included in organised training.

During the first year of work, monthly training sessions were run by the CHST for all Homes. These were focussed around areas of perceived and identified need for training. It

was found that these were not always very well attended due to staff shortages and poor levels of funding for training within the Homes. Therefore the CHST decided to change the way they provided training and instead targeted Homes with in-house training and help to implement policies within the Homes. This has generated a great deal more interest and allows the team to have contact with an increased number of staff at each Home.

The areas of training include: The Ageing Process, the Falls Prevention knowledge of the Active Ageing project, palliative care and End of life training, clinical training on site e.g. catheterisation, work with specialist nurses to co-ordinate training, as well as development of training to complement the policies and paperwork the CHST have developed.

The need for “accredited” medication training for Care Home staff who deal with medication has been identified as required by the Commission for Social Care Inspectorate (CSCI), many of the Homes do not have ready access to medication training and updates. The pharmacist has identified ways of targeting this through a local college who provide nationally accredited training and will spread this to Homes which require it.

One example of an area of training need in basic care is in Contenance, catheterisation and catheter care. This is a problematic area for many homes and there is evidence of a number of hospital admissions caused by blocked supra-pubic catheters due to staff not following the catheter maintenance regime. This causes pressure on District Nursing teams who often called in to perform catheterisations on nursing clients because the home have been unable to deliver that service.

The CHST have been able to provide support to both the Home staff and District nurses on this, and have been contacted for advice on several individual clients. The team are also working closely with the specialist continence nurses to improve access to their training.

The CHST will continue to develop training for staff and improve the access to existing training by working with the Workforce development confederation, social services and specialist nurses.

3.4 Improvements in management of palliative care in Care Homes

One key area that the CHST have identified a need for improvements is support for Care Homes is in the provision and knowledge of palliative care.

Much work has been done to improve support for Homes in this area, including:

- Close links have been developed with Great Oaks Hospice - A rotational post has been developed for Care Homes Nurses. They have the opportunity to attend the hospice one day per week for six months where they can develop their skills in palliative care. The palliative care at the hospice is focused on people with chronic illnesses as well as cancer enabling the nurses to relate their new skills to their Care Home environment. Nurses are able to access training from the Hospice even following the completion of the 6 months placement.
- The Countywide palliative care pathway is being introduced for end stage client care. The nurses from the Team will be working on an individual basis with care homes to implement this for individual clients. There are also links with specialist nurses working with the GOLD standard framework for palliative care who have agreed with the CHST nurses to pilot work on the framework in Care Homes in our area.
- Certification of death – Nurses are able to certify death, but in Care Homes this is rarely done. The CHST nurses have received training to become champions of this and will be able to pass on their training to encourage Care Home Nurses to use this.

- Syringe drivers – At present District Nurses are being used to set up drivers for nursing clients receiving palliative care in many Homes. This is not always a good use of time and there are risks involved in Home staff not knowing how to use the drivers themselves. The CHST Nurses are to attend syringe driver training to enable them to assist homes with setting them up and, eventually to train Home staff and empower them to use them independently. For this purpose a free training pack has been obtained from the Macmillan Nurses charity.
There has also been some work involved in ensuring all Care homes have access to a syringe driver and palliative care drugs out of hours.

The aim is for Care Home nurses to develop the skills and have support from the CHST to enable their clients to receive appropriate end of life care in their preferred place of care as opposed to needing the hospital setting.

A recent example of the benefits of this occurred when the CHST nurses were called into a home by the District nurse team to assist with end of life care for a client. All care was reviewed with Home staff, relatives, CHST and GP. A hospital admission was avoided and inappropriate prescribing stopped. The client died peacefully in a familiar environment.

3.5 Policies and paperwork

Throughout the work of the Care Home Support Team, the benefits of standardised paperwork for all Homes have been very evident. Managing chronic disease requires active surveillance and early intervention at the first signs of deterioration. Care Homes need to provide client-centred nursing and must implement a preventative approach to reduce further deterioration or slow the process down. The benefit of standardised assessment tools and good quality assessment of clients is well documented in published evidence, and is a key standard of the National Minimum standards for Care Homes. Both Social Services and CSCI recognise this as a current failing of many Homes, so in response to these findings the CHST has worked to develop and implement some standard paperwork. As well as helping to provide the Homes with this paperwork, the Team have trained staff on the use of the paperwork and regularly reviewed the progress which has increased the success of its implementation.

The Royal College of Nursing Admission Assessment Tool – this ensures that all clients are comprehensively assessed to a high standard on admission to a Care Home and allows the Care Home staff to produce individual quality care plans for each client which can be regularly revised and updated.

The Daily Patient Profile (“Traffic light paperwork”) is a method of recording a client’s overall condition on a daily basis. It is a visual tool which will alert staff if a client’s condition is deteriorating, and prompt them to take action. It encourages proactive rather than reactive treatment and should therefore prevent emergency admissions to hospital.

The DPP incorporates the Barthel Index, encourages nutritional screening, the monitoring of skin integrity and monthly weighing. These are all areas that have been identified as often inappropriately monitored and which can all create a financial drain on resources if they are not managed effectively.

The DPP and RCN tool together assist with implementing the most appropriate care for each client, and monitoring its effectiveness. They were piloted in 3 homes, and adjusted and updated according to the results of the pilot, and are now available for use in all Homes. The CHST nurses are also working on some standard “generic” care plans to complement both the DPP and RCN tool.

A policy for managing suspected Urinary Tract Infections in Care Home residents was developed by the CHST in collaboration with Microbiology, and training on this has been issued to a number of Homes. This aids a more rational approach to assessing urinary symptoms, and more appropriate use of MSU testing. Feedback from a number of homes

has said that this document has empowered them to challenge a decision on antibiotic usage and has prevented inappropriate prescribing of antibiotics.

Best practice folders – The CHST has developed robust evidence-based guidelines in areas such as monitoring of blood pressure, recording blood testing in Homes and monitoring of blood glucose. These were developed in response to an identified variable standard of care for the monitoring of long term conditions in Care Homes. All of these guidelines have been included in the CHST Best Practice folders which are provided to the Homes along with training. These can be added to and updated as more evidence is produced and the training of the CHST continues, and they should provide an easy reference source for Care Home staff.

3.6 Medication reviews

It is well documented in published evidence that Care Home clients do not receive the same level of medication review as Older People in the community. Care Home clients are also more likely to suffer the consequences of polypharmacy such as adverse drug reactions.

In order to target these issues and improve the prescribing for Care Home clients in West Glos PCT area, the CHST GPs initial work included medication review for individual clients, with written advice sent to the patient's own GP. However, after a number of Homes, it was concluded that this was not the most effective model for medication review. This led to the employment of a pharmacist to target these issues.

The pharmacist has developed a thorough methodology for medication review, which includes review of the resident's medical history as well as their prescriptions. Once these reviews are completed the results are fed back to the resident's own GP in the form of recommendations. This work has led to a large number of recommendations and a very high uptake of the advice by GPs.

The recommendations fall into three broad categories:

- Changes to improve chronic disease management for the client (to optimise current therapy) and allow the most up-to-date and evidence based guidelines to be used in Care Homes
- Changes to reduce risk to clients from medication related problems (e.g. side effects, falls related to medication).
- Changes to medication to provide the most cost effective method of prescribing (e.g. encouraging Homes to restrict wound care dressings to the PCT Dressings formulary).

The medication reviews for individual clients have generated a reduction in drugs wasted in Homes, and cost savings related to reducing the number of drugs taken by clients and changes to more cost effective prescribing. The medication reviews have also identified prescribing problems that are common to more than one client or Home, and so guidelines and general advice have been generated on a wider scale.

If the pharmacist is working 3 days a week it is estimated that they would review 1000 clients in 12 months, and save in excess of £79,000.

Through the direct communication between the pharmacist and the Homes many other areas of previously unidentified need have been uncovered. These include the understanding of monitoring of blood pressure and glucose, regulation of blood tests for monitoring of long term conditions. There have also been issues identified relating to the safety of medication administration in individual Homes, and in some Homes the systems for ordering and receiving drugs have been reviewed and improved.

This role has most importantly improved the prescribing for clients in Care Homes, it has also allowed improved communication links between Homes and GPs and Homes and Community pharmacies who are responsible for the supply of medication.

3.7 Development of improvements in monitoring of long term conditions

Many studies have shown that chronic disease management is inferior for residents in long-term care. The CHST decided to tackle this by introducing a system of increasing the number of clients who would have regular blood tests. If the client fitted into criteria for requiring regular blood tests (i.e. have certain medical conditions, are on certain drugs) then they would have a blood test sample taken once every 6 months, and all clients in one Home would be tested at the same time. This system was run for a trial period at the start of 2005. The CHST employed a healthcare assistant who was responsible for visiting the Home and taking the blood samples after the clients had been identified as part of their medication review. Results of the blood tests were sent directly to the resident's GP. An audit of this system revealed that of the clients tested, a proportion were found to have previously unrecognised medical conditions (for example, clients with a degree of renal failure, anaemia, signs of diabetes), and others required adjustments to drug regimens to maintain management of their conditions. Limitations of the system were that it was difficult to pick up whether abnormal results were being acted upon by the doctors, doctors were often not aware that the tests had been taken and effort was duplicated, that it was very difficult for Homes to cope with up to 60% of their clients having a blood test on the same day

Therefore, although this project did produce positive results and was generally considered effective, the time constraints and logistics of the operation made it impractical to continue. It should however, be considered as an area where Homes do need support and could be re-visited in the future.

3.8 Supply of client's medical information to the Care Homes

Through the medication reviews, the RCN screening tool, and through general experience within Care Homes it became apparent that Care Home staff often have very little knowledge of the medical diagnoses in their residents. This can impact both on the care the client can receive from Home staff and also the knowledge of the patient available to out of hours medical staff. To address this, the CHST developed a system for Homes to keep medical summaries for their clients which are sent from the GP surgery to the Care Homes on a regular basis (6 monthly). This procedure was agreed by the PCT Caldicott committee, with some safeguards such as storage requirements and the need for client consent. This has been very useful in allowing Homes to have a comprehensive picture of the care needs of their residents.

3.9 Rationalisation of provision of Medical services to Care Homes

Again, through various aspects of its work, the CHST observed that the quality of medical care for Homes is variable. The care often appeared of a better standard where a Care Home had a clear link with one doctor's surgery, or just a few surgeries. From this observation the team worked on a system to reduce the number of surgeries each Home had to deal with (from 13 in some cases) down to three per Home, who will act as the "preferred surgeries" for that Home, while preserving the client's right to choice. Indications so far are that this approach would be appreciated by GP's and Care Homes, and it has been agreed that this will happen gradually over time as new clients are admitted to the Homes.

3.10 Case load management of complex clients in Care Homes

In line with the national emphasis on management of clients with long term conditions by nurses in primary care working with a caseload of patients, the CHST nurses are at present working in three Nursing Homes, assisting with complex cases which would otherwise have to be managed in hospital.

Of these clients, all have been prevented from being admitted to hospital; two clients died peacefully in their Care Homes rather than hospital and a third client is improving steadily. Through the CHST providing hands on training with these clients the Care Homes have been empowered to care for future clients independently.

This management of complex clients has built important links with other healthcare professionals such as district nurses and Tissue viability nurses, it is expected to become an important area of work for the CHST nurses, along with continuing to provide training to improve the basic skill of Care Home staff.

3.11 Liaison with specialist nursing resources

The CHST nurses have established collaboration with Specialist Nurses in specific disease areas. Not only has this allowed Care Homes access to the knowledge of these nurses, it has also established that these nurses feel unable to respond to the potential demand within the Care Homes, and feel that Care Home specialist nurses are more appropriate.

District nurses and a number of social workers have contacted the Team regarding specific clients for advice in Care Homes, creating an informal referral route to the CHST nurses as Care Home specialist nurses.

The CHST nurses have identified specific areas that the Care Homes need to address such as skin integrity, nutrition and wound care. It has become apparent that many Nursing Home staff have become deskilled in these areas of basic care, feel very isolated, and due to the lack of capacity of specialist nurses, this is causing reactive care which is not in the best interest of the client and is a drain on financial resources.

To alleviate this problem the Nurses on the CHST are developing their skills using the Specialist Nurses and disseminating this knowledge to the homes, theoretically, with teaching sessions and working with staff and clients to link the theory to practice.

Other specialist services which have been working in collaboration with the CHST include increasing the availability of training for Care home staff from the specialist Diabetes Nurses, the continence nurses, and palliative care. The Team have also arranged for some nutrition training to be started, working with the Dieticians at the hospitals trust.

A commonly used approach is for the CHST nurses to update their own knowledge through contact with these nurses and for them to disseminate the information during in-house training sessions in the Homes.

Heart failure is one of the chronic diseases common in Care Homes, and liable to precipitate acute admissions. The CHST GPs explored how care may be improved with collaboration with the PCT's Heart failure project. This led to a pilot in 3 Homes where patients with uncertainty about the diagnosis were identified and referred for echocardiography at the Care Home by the Heart Failure nurses. Although this was felt to be a useful area of focus it was not able to be continued due to the extensive workload of the Specialist Heart Failure Nurses.

3.12 Work on a policy for advance directives and Do Not Resuscitate guidelines for clients in Care Homes

It has been widely observed that Care Homes do not always have the appropriate support in helping their residents make decisions at the end of their lives. Without fully documented and agreed decisions this can result in traumatic and unwanted hospital admissions and treatment.

The CHST, in collaboration with many parties, have been involved in developing a policy on advance directives and DNAR decision making in Care Homes and the Community. Once finalised, the CHST will provide training and support for Homes in implementing it as well as publicity to all healthcare professionals involved in the care of these clients.

3.13 Work with Care Homes in Crisis

As the role of the CHST has become more widely known it has been used as a resource to help Care Homes who are struggling. In some cases this had been done early enough to avert crisis, and useful recommendations and changes have been made.

One Home in particular were facing possible closure, the CHST worked with staff on the floor to assess where support was needed. Once the needs were identified, the team provided training sessions within the Home for Care Assistants and Nursing Staff, medication reviews for all clients, and the home have recently joined the Active Ageing programme. This Home has remained open and the CHST will continue the support systems we have implemented. The home have become very receptive which is the first step required to improve standards.

3.14 Collation of data on hospital admissions from Care Homes

The CHST have been asked if it is possible to focus work on avoidance of hospital admission for clients in Care Homes. Much of the support and work the CHST undertakes will achieve this aim by improving quality of care and knowledge of Care Home staff, but the team decided that there are too many variables to be able to directly say that our work reduces hospital admission. It was decided to continue the focus on improving basic standards in all Homes.

In order to investigate this further it has been necessary to collate data on hospital admissions from Care Homes, the information department at the Hospitals Trust has now developed a methodology for identifying admissions from Care Homes (previously impossible because PAS does not code for residence on admission), and so this can be monitored regularly.

CHST has obtained valuable data on these covering last years' admissions to hospital. This data will be used to target specific homes where admissions are high. If the causes are due to a lack of training/skills the CHST will be able to implement the necessary action to reduce admissions.

4. FUTURE DIRECTION

From all of the work that has been carried out by the CHST so far there is an obvious need for a team to continue to support Care Homes. There are areas of key benefit which the team feel are essential to continue with, and there are new areas which require more development to come to fruition.

Areas which will be focussed on in the future include:

Communication

- Continuing to strengthen links with specialist workers who have skills that Care homes will benefit from, and aim to link with voluntary agencies too.
- Working more closely with other healthcare professionals who work with Care Homes in this area (e.g. RNCC nurses and Continuing Care Assessment teams).
- To strengthen links and share practice with other Care Home Support teams in other areas (such as the Lambeth Care Homes Support Team).

Training

- To continue with the importance focus of training all staff in Care Homes, and to work with agencies such as the Workforce Development confederation and social services.

- To continue to develop the basic skills of staff in all Homes in order to raise the quality of care possible. Once the Homes feel empowered and are more confident in delivering basic nursing care, the CHST Nurses will turn their focus on increasing the Nurses' clinical skills introducing phlebotomy and Intravenous and subcutaneous fluid administration training which would increase the care available in the Homes.
- To continue to develop up to date policies and guidelines with training for all Homes.

Case load management

- The CHST nurses will continue to develop their Caseload approach to managing complex, vulnerable clients in Homes. This will be done in line with the PCT approach to nurse led case management.

Improving standards

- To continue to work with regulatory and contracting bodies such as Social services and CSCI to emphasise the need for improved standards in Homes, and to pursue the work to incorporate the CHST improved policies and procedures into the countywide contracting process.
- To continue to champion high quality medical care, including medication reviews and medicines management for all clients in Care Homes.