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Evaluation of an advance care planning education programme for nursing homes: A Longitudinal study

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SUMMARY

Purpose: To evaluate the success of a programme of Advance Care Planning education for nursing homes by examining the effect on staff knowledge, Advance Care Planning practice within the home and end-of-life hospital admission rates.
Method: Three longitudinal questionnaires assessing staff knowledge, Advance Care Planning Practice and hospital deaths completed before and after the initiation of the Advance Care Planning education programme by homes that had completed the training and those yet to undergo the training.
Results: Superior Advance Care Planning knowledge was evident in those staff that had completed the training. There was an increase of 85% in the number of Advance Care Plans completed in the training homes and an overall reduction in hospital deaths of 25% for residents from training homes.
Conclusion: A programme of Advance Care Planning education for nursing homes is successful in improving nursing home staff knowledge, increasing Advance Care Planning practice and reducing hospital deaths.

Introduction

There are approximately 18,500 nursing homes in England providing accommodation as well as nursing and personal care, with around 400,000 beds; it is estimated that between 92,000 and 119,000 of these residents die each year, representing between 19% and 25% of all deaths per year in England (NAO, 2008).

The End of Life Care Strategy, published by the Department of Health in 2008 with the aim of setting out a vision for giving people approaching the end of life more choice about where they would like to live and die, highlighted the accumulating evidence that many nursing home residents are transferred to hospital in their last days or weeks of life when this may not be their wish or in their best interests (DH, 2008).

Advance Care Planning (ACP) entails discussions and documentation of individuals' wishes and preferences for their future care. It is a means of improving end-of-life care by allowing planning and provision of care in line with patients' and their carers' priorities at a time when they may not be able to communicate their choices. ACP can include advance statements detailing patients' particular needs and preferences, advance decisions to refuse specific treatments which may be offered, such as non-oral feeding, and the appointment of a person to make decisions regarding care in the event of loss of capacity, e.g., Lasting Power of Attorney (Brinkman-Stoppelenburg et al, 2014).

Evidence shows that older people want to discuss end-of-life issues (Murray et al, 2006), and it has been demonstrated that ACP can have a range of positive outcomes, including achievement of end-of-life preferences (Molloy et al, 2000; Detering et al, 2010) and in particular reduced end-of-life hospital admissions (Ratner et al, 2001; Degenholtz et al, 2004; Caplan et al, 2006). ACP can be particularly relevant and important for residents of nursing homes (Sharp et al, 2013 and Stone et al, 2013). These individuals are usually older and increasingly frail (26 % of those over 85, Clegg et al, 2013) may be in the last years of life and recognise that this is the setting where they will spend the remainder of their life (Mathie et al, 2012).

Both the End of Life Care Strategy and the Healthier Horizons for the North West (a paper published by the Strategic Health Authority detailing a vision for the health of people in the North West of England) recommend training to enable care home staff to carry out advance care planning for residents, with one anticipated outcome being reduction of inappropriate hospital admissions (DH, 2008; NHS North West, 2008). The Gold Standards Framework in Care Homes programme (GSFCH, 2004) is the most widely used end-of-life care training programme for care homes in the UK (Thomas and Lobo, 2011). It has pioneered the education around ACP for care homes and been shown to demonstrate positive outcomes for residents, staff and relatives (Kinley et al, 2013); however, it is costly and requires facilitator support.

The variable prevalence of ACP in care homes currently is in part down to lack of staff knowledge and confidence as well as other resident, family and communication factors (Froggatt et al, 2009; Stone et al, 2013). The ACP facilitator role for nursing homes in Wigan, a 'working class' town in Greater Manchester, England, with a population of approximately 97,000 was developed in response to the initiatives

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described above (DH, 2008; NHS North West, 2008) and began in April 2011 as a fixed 2-year post. The initial task of this project was to develop a programme of ACP training for nursing home staff, the 'intervention' in this study. The programme is based on the Gold Standards Framework in Care Homes programme (GSFCH, 2004) and responses to a baseline questionnaire carried out by the ACP facilitator to gauge local training needs. It consists of four workshops of around two hours each delivered over a period of 4 to 6 weeks covering 'Introduction to ACP', 'Legal and Ethical Issues', 'Communication' and 'Documentation' delivered using a combination of didactic teaching and interactive learning strategies such as role play and case study discussion, a format which has been shown to be associated with successful courses (Pulsford et al, 2013).

Purpose

To evaluate the success of a programme of ACP education for nursing home staff by examining its effect on staff knowledge, ACP practice within the home and end-of-life hospital admission rates from the nursing home.

Methods

Sampling and Recruitment

There are twenty registered nursing homes in the Wigan borough. By August 2012, thirteen of the nursing homes had completed the training programme, with seven remaining to undergo the training between August 2012 and Spring 2013. All nursing homes were invited to participate in the study. The nursing homes are all privately owned by a number of different proprietors and vary in the number of beds they comprise.

A letter was sent to each nursing home manager of the homes whose owners had given consent, explaining the study and asking them to contact the researcher if they wished to participate. In nursing homes that agreed to participate, questionnaires and participant information sheets (PIS) were then left for staff to collect or sent to staff to complete.

The study population was all health care assistants and qualified nursing staff in all registered nursing homes in Wigan that consented to participate. Staff that did not have resident contact were excluded. Residential care homes were excluded.

Data Collection

Three surveys were used to collect the data to address the study purpose:

i) Knowledge-based questionnaire consisting of twelve fact-based questions on ACP with True/False/Don't Know responses designed by the ACP facilitator to test the awareness and understanding of ACP by individuals. A score of one point for each correct answer was awarded. This questionnaire was completed by staff from nursing homes that had gone through the training programme by August 2012, at the first training workshop (pre-intervention). Post-intervention, the same questionnaire was administered to all staff at all nursing homes that agreed to participate in this research, whether they had been through the training programme or not.

ii) Survey of ACP practice within the nursing home (adapted by the ACP facilitator from the work of Froggatt et al, 2009), intended to ascertain the home's current level of engagement with ACP and completed by each nursing home manager. This survey collected data on ACP practice within the home looking at attitudes, confidence, and values around ACP; tools in use by the home; staff involved in ACP and also included the number of advance care plans in place at the point of question for their current residents. The survey was administered to all nursing homes at the beginning of the project by the ACP facilitator and repeated by the researcher post-intervention.

iii) Survey collating data on resident deaths completed by each nursing home manager. Nursing home managers were asked to record the number of nursing home deaths, hospital deaths and reason for and length of admission to hospital prior to death for each month of the year retrospectively. Data on hospital deaths were collected by the ACP facilitator for the 12-month period before the initiation of the project and was repeated for the period 1st August 2011 (2 months after the start of the ACP training programme for nursing homes project) to 31st July 2012 (the start of the research period).

Data Analysis

The responses to the twelve questions on the knowledge-based questionnaire from both the original questionnaires administered before the training programme and the questionnaires administered in this study period were entered onto SPSS Statistics (version 20) and the percentage of correct answers calculated.

The means and 95% confidence intervals of the scores on the original pre-intervention questionnaires were calculated and compared with those post-intervention questionnaires completed by those having undergone the training. This was done individually for each of the twelve nursing homes that had received the training to date, and also as a pooled sample.

There was also a comparison of means between the post-intervention questionnaire results of those participants that did complete the training with participants who did not complete the training but work in nursing homes where the training had been delivered and with participants in nursing homes that were yet to receive any training, using a one-way analysis of variance test.

Numbers of advance care plans detailed on the ACP survey completed by nursing home managers both before the training intervention and after were entered onto SPSS Statistics (version 20.) The two sets of figures were compared to each other for each individual nursing home and analysed using descriptive statistics. There was also a pooled data comparison of all the homes' baseline answers with those following the training intervention.

The number of nursing home residents that died in hospital each month between April 2010 and March 2011 and the number of nursing home residents that died each month between August 2011 and July 2012 as recorded on the hospital death survey were entered on to SPSS Statistics (version 20) and the numbers compared. The total number of deaths was compared rather than the number of deaths month by month as the hospital admission rate and death rate is likely to be affected by the month of the year. A comparison was made for each nursing home and also a pooled data comparison.

Ethical Considerations

Wigan and Leigh Hospice was the host organisation providing governance support for this study. This study did not require research ethics committee approval according to the Department of Health governance arrangements (DH, 2011) as it did not involve collecting data from patients. This position was confirmed with the National Research Ethics Service by consulting the Local Research Ethics Committee (North West).

Each care home proprietor was contacted to seek permission via their individual approval process to access the manager and staff in their care home and administer the relevant questionnaires.