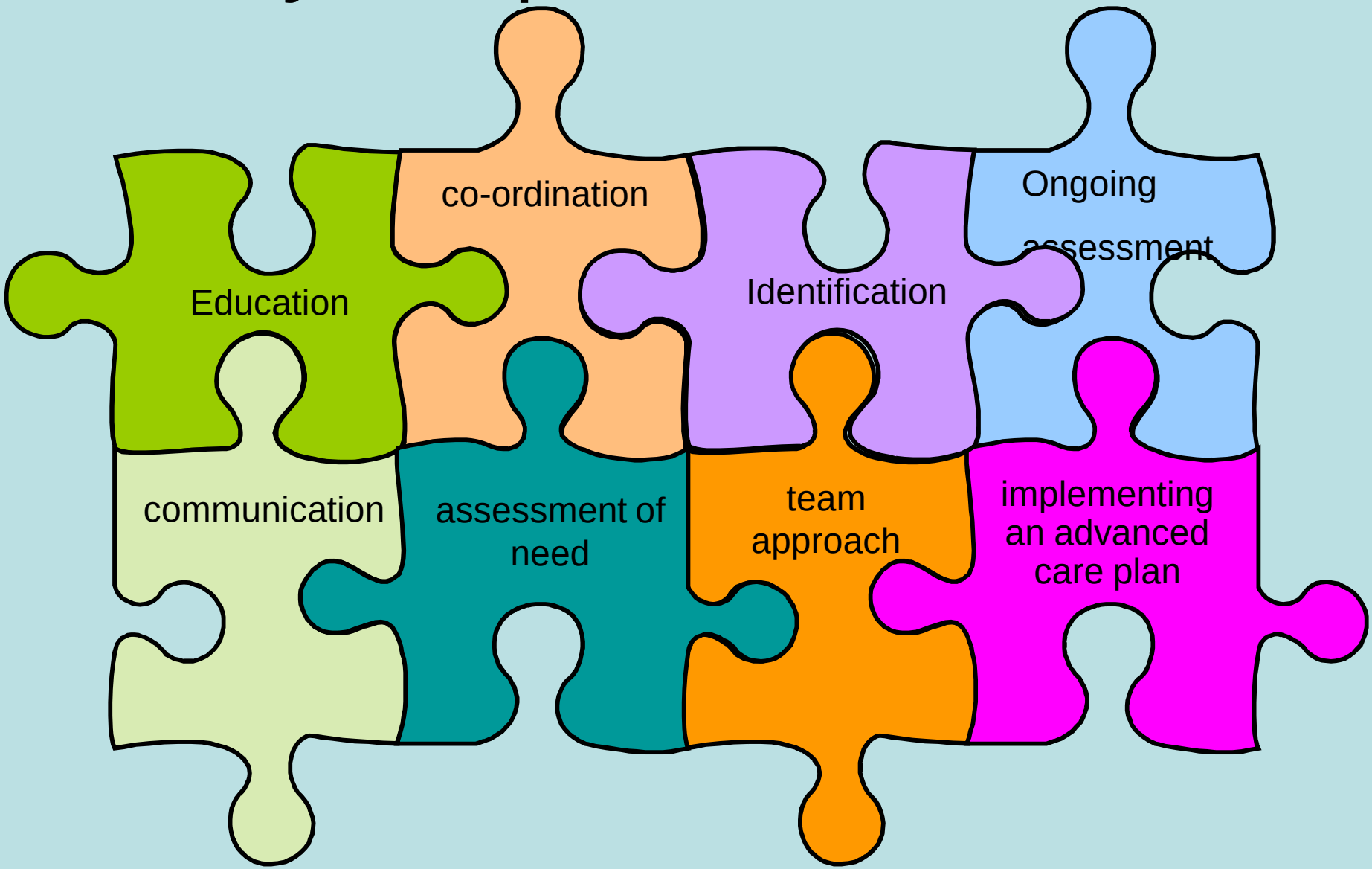
the gold standards framework in care homes

# GSF IN CARE HOMES

# Context

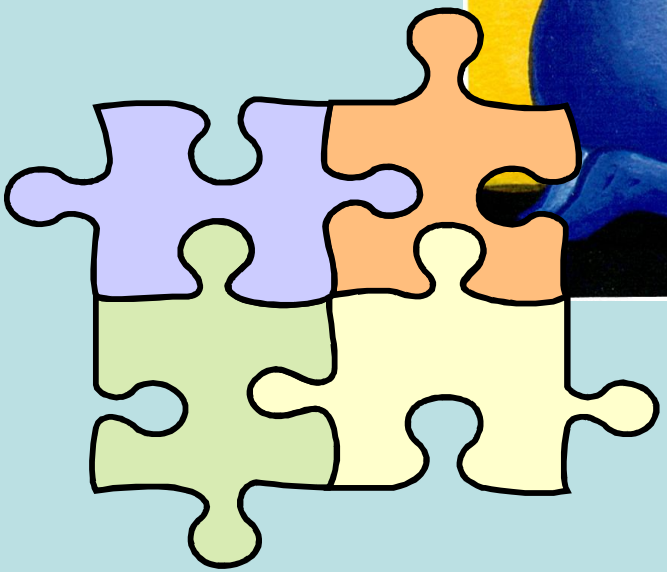
- **Half a million people live in Care Homes**
- **Approx 20% people die from all causes in Care Homes**
- **For every NHS bed there are three Care homes beds**
- **The Care Home  sector employs about 1.2 million people**

# Key components of EOLC



# GSF is part of the jigsaw

GSF is part of the jigsaw to enabling proactive end of life care for all.



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# GSF Care Homes Programme

"*The biggest palliative care initiative in care homes so far*"

Aims

1. To improve quality of end of life care
2. To improve collaboration with primary care and specialists
3. To reduce admissions to hospital in the last stages of life

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# A good death for all

“Our aim is that every person should be able to live well and die well in the place and in the manner of their choosing”

# Goals of GSF

***Patients are enabled to have a 'good death'***

1) **symptoms controlled**
2) **in their preferred place of choice**
3) **Safe +secure with fewer crises.**
4) **Carers feel supported, involved, empowered, and satisfied.**
5) **Staff confidence, teamwork, satisfaction, co-working with specialists and communication better.**

# The GSF Care Homes Training Programme Four Gears

## 1. Getting going

1. Coding, Register
2. Meeting,
3. Coordinator

## 2. Moving on

1. Assessment of symptoms + Advanced care Planning
2. Out of hours continuity
3. Education and reflection

## 3. Gaining Speed

1. Carers and family support Bereavement (and staff)
2. Education and reflection
3. Care in Final days

## 4. Cruising

1. Sustain
2. Embed
3. Extend

# 7 Key tasks/ standards-The GSF 7 Cs

**C1** Communication

SC Register and HCT Meetings, Pt info, PHR,
Advanced care planning (ACP) e.g. PPC

**C2** Co-ordinator

Key Person, assessment tools e.g PEPSI COLA

**C4** Continuity Out of Hours

Handover form + OOH protocol

**C5** Continued Learning

Learning about conditions on patients seen

**C6** Carer Support

Practical, emotional, bereavement, National Carer's Strategy

**C7** Care in dying phase-

LCP / ICP for care in last few days

# Take Small Steps to Change

- Ethos of GSF: don’t run before you can walk – go at the pace right for you
- Adapt and adopt –make GSF the norm.
- Change in practice takes time, commitment.
- Don’t lose sight of changes made: big and small

# What does using GSF change? 3 areas

## 1.Attitude awareness and approach –

- **Better quality** of care perceived
- Greater confidence and job satisfaction
- Immeasurable benefits- communication, teamwork, roles respected esp DNs
- Focus + proactive approach**,**

## 2.Patterns of working, structure/ processes

- **Better organisation + consistency** of standards, even under stress
- Fewer slipping through the net- raising the baseline
- Better communication within and between teams, co-working with specialists
- Better recording ,tracking of pts and organisation of care

## 3. Patient Outcomes

- **More pts dying in preferred place**
- **Reduced crises/ hospital admissions** /length of stay
- Some doubled home death rate
- More recorded Advance care planning discussions

# Care Home Staff Reflections

## on what GSF has meant to them.

- “GSF means caring in the best way till one dies” (Care Home RGN)
- “More confident working as a team with other staff, GPs and hospice nurses” (RGN)

- “Able to fulfil patient’s wishes because you know in advance what they want and are prepared. The transition is smoother running in relation to their medical condition” (Deputy Manager)

# Staff reflections on GSF following implementation

- **“GSF has given an insight into a very delicate subject – I have learnt to question more about all available alternatives and to offer assistance that I didn’t know existed” (Care assistant)**

- **“**GSF has made my work **simple** to care for my residents**.** It has drawn m**e closer** to my residents and relatives, given me **confidence** in discussing end of life care**.”**

  (Nursing Home RN

- “It has helped them in their **confidence**….and to feel they are **valued** as nurses” …The girls have more **confidence** talking to GPs and taking the initiative” (Manager )

- “ To me GSF means how best we can make the lives of the dying comfortable, meaningful and memorable as a team…….” (Chef)

# Reactive patient journey-

## *MR B in last months of life-*

- Care Home –no discussion wishes for end of life (only burial/cremation) -no PPOC discussed or anticipated
- Problems with symptom control-high anxiety
- Crisis call e.g. OOH-no plan or drugs available - GP sent ambulance
- Admitted to hospital – disorientated.
- Dies in hospital ?over intervention/medicalised
- Carer support in grief by care staff
- No reflection/improvements by care home/GP
- ? Inappropriate use of hospital bed

# GSF Proactive pt journey-

# Mrs W in last months of life

- Coded on Register-discussed at Care Home GSF meeting
- Focus of care at stage of life
- Regular discussion and planning with care home/GP/SPC - proactive care
- Assessment of symptoms -referral to SPC-customised care for resident
- Carer involvement in care/decision (residents wish)
- Advanced Care Plan completed with resident and family - Preferred place of care noted and planned.
- Handover form issued –ACP wishes – anticipatory drugs issued in care home
- End of Life pathway/LCP/protocol used
- Pt dies in preferred place- the care home fully supported by well trained staff. Bereavement support – for all .
- Staff reflect-ADA and SEA - audit gaps improve care, learn

# In hours Proactive Palliative Care-

Avoidance of crisis-eg GSF

***Anticipatory care helps avoid crises***

-improved support for families + staff

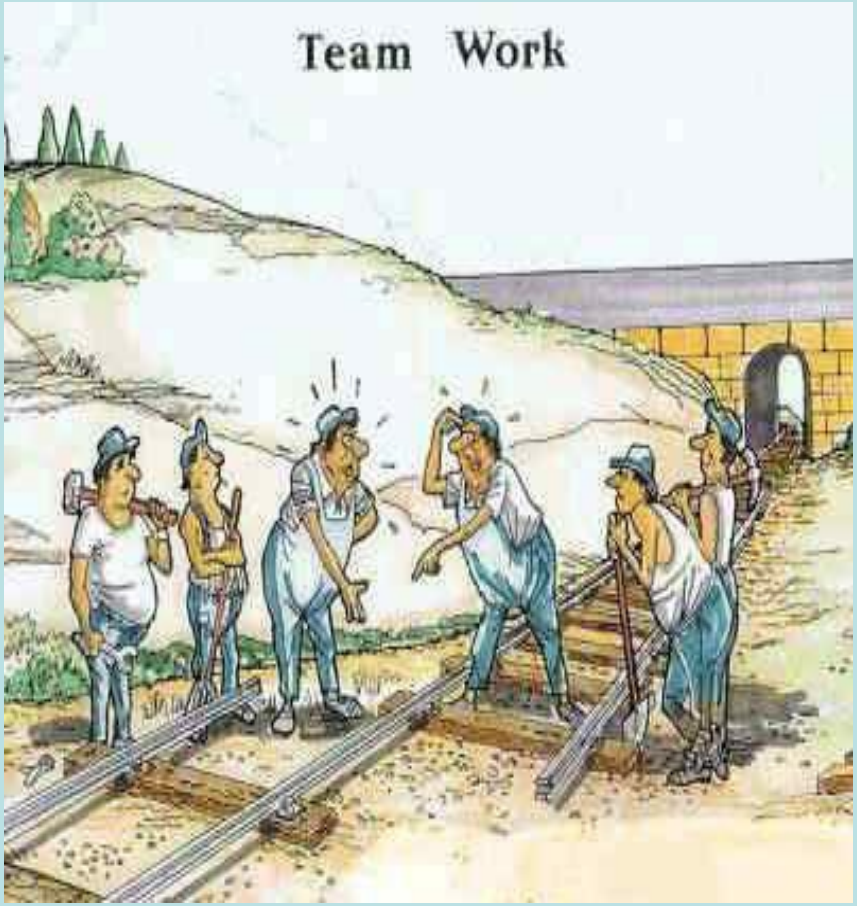
-reduction in hospital/hospice admissions

-achievement of preferred place of death

***….and reduce fear***

# Improved Communication

- Improved team work
- Improved sharing of information
- Improved communication with specialist palliative care
- Improved communication with patients and carers



# End of Life Care-
# Getting it right

They'll never forgive
you
if you don't

They'll never
forget you
if you do