Providing nursing support within residential care homes

Findings
Informing change

April 2008

This study examines a joint NHS-Local Authority initiative providing a dedicated nursing and physiotherapy team to three residential care homes in Bath and North East Somerset. The initiative aims to meet the nursing needs of residents where they live and to train care home staff in basic nursing.

Key points

- Hospital admissions and nursing home transfers were prevented. Care home staff and managers preferred residents to be able to stay in their home when they were ill, as did residents themselves.
- Enhancing health-orientated education and training of care home staff was challenging at first but relationships improved, and the confidence and professionalism of care staff grew.
- Residents' nursing needs cannot simply be equated with their level of dependency. For example, a resident with dementia can be functionally independent yet have major, often un-communicated health needs.
- The early detection of illness and resulting opportunity for early intervention was a major part of the team's work. Residents were likely to benefit from improved quality of life.
- Overall, estimates of costs and savings ranged from a 'worst case' scenario of £2.70 extra to a more likely scenario of £36.90 saved per resident per week. Savings were mainly in reduced use of NHS services, while the Primary Care Trust and Adult Social Services both funded the intervention, highlighting the need for partnership working to sustain funding.
- The researchers conclude that any increase in cost should be measured against the benefits of promoting long-term quality of life, quality of care and providing a firm foundation for future workforce development.

The research
By a team from the University of the West of England, Bristol, and the University of Warwick.

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Background

Over the last 20 years, changes in health care provision have resulted in increased reliance on community services, focusing the NHS role towards one of acute care provision. Estimates suggest that there are now some 440,000 places in the registered care home sector, most of them for older people.

The *National Service Framework for Older People* (Department of Health, 2001) formed the basis of successive policy for the reconfiguration of services in the care sector as a whole. Policy has indicated particular interest in the provision of intermediate care and the promotion of partnership working, including multi-agency assessment.

Within the care home sector in particular, it is recognised that there are differences in the management of homes and access to NHS nursing and other expertise. The involvement of care homes in rehabilitation is also acknowledged to be variable. The training and education of care home staff is seen as crucial in addressing the complexity and dependency of older residents' needs and ensuring a good quality of care.

This study reports on an evaluation of an initiative in Bath and North East Somerset (B&NES) involving the Local Authority and the Primary Care Trust. In this area, a dedicated team provided nursing and physiotherapy to support up to 131 residents in three local authority residential care homes. The team members also supported enhanced health and nursing training for designated care staff within the homes.

Prevention of hospital admissions and nursing home transfers

Evidence from interviews and focus groups suggested that enabling residents to stay in their home when they were ill was preferred by care staff, managers, and most importantly by residents, who gained a greater sense of security from continuity of care in a familiar environment.

Audit data suggested that the nursing and physiotherapy expertise from the nursing team, combined with their support for the development of new types of working amongst designated care home staff, was able to avert between 81 and 197 potential hospital admissions over the first two years (between July 2005 and June 2007). In addition, 20 early discharges were facilitated.

Over the same period, a comparison of hospital data from the homes involved in the pilot scheme shows a decrease in admissions for more than 48 hours and an increase in those of less than 48 hours. This suggests the model has had a positive impact in preventing longer admissions and facilitating early discharge. However, the time span of two years was too short to demonstrate a meaningful trend in either type of hospital stay.

Audit data also suggested that the nursing team's work prevented 20 (or possibly up to 28) residents from being transferred to a nursing home.

Savings to the local authority and Primary Care Trust will vary depending on whether this represents a delaying mechanism for transfers to nursing homes or a longer-term measure for preventing them. Again, the time span was too short to demonstrate the long-term effect.

Resident dependency

Results of assessments carried out using the Minimum Data Set (MDS) care assessment tool indicated nursing needs in a majority of residents, whereas care staff's routine assessment scores, based on residents' ability to carry out Activities of Daily Living, indicated dependency needs in only a minority of residents drawn from the same population. As the two scores measure different things, this should not be viewed as conflicting evidence. For example, a resident with dementia can be functionally independent yet have major, often un-communicated health/nursing needs.

However, the findings do suggest it is important for residents to receive a more comprehensive routine health assessment than one which is focused on functional 'activities of daily living', as a precursor for better care planning and intervention. This has implications both for the knowledge level required by care home staff taking on 'new types of working' roles and for the level of support they may require from a nurse.

Detection of illness

The early detection of illness and resulting opportunity for early intervention was a major part of the nursing team's work, accounting for a high number of visits to residents to deal with conditions uncovered. Although it is possible to estimate the impact of this in terms of cost (per visit), it is not possible to determine savings. Indeed it could be that uncovering often complex health needs will increase initial costs but create long-term savings in preventing the deterioration of people's health. However, there are likely to be benefits to residents in terms of improved quality of life, in particular for individuals who have problems communicating their illness and its symptoms.

Contribution to teaching and learning

Another important area of work for the nursing team was to enhance the 'new types of working' amongst designated care home staff, supporting them in their move towards new health-promoting roles and responsibilities. There were early challenges with this in the first year of the project, when each group was perceived by the other as being 'too set' within their particular discipline (nursing or social care). However, understanding and mutual respect had improved by the second-year staff interviews and care staff were more confident in performing new roles. These improvements are backed up by related audit and quality assurance data which shows the amount of time given by the nursing team to teaching and clinical supervision in both a formal environment and informally in the homes. By the last phase of the study, evidence suggested that the team had adopted a case management or person-centred approach (as opposed to the task-orientated approach observed earlier in the study). This was more beneficial to building relationships with those in new roles and in the establishment of the home as a learning environment.

Costs and savings

Estimates of costs and savings suggested that the cost of the pilot (£43.94 per resident per week) might in the 'worst case' scenario exceed the estimated savings made in the same period by £2.70 per resident per week. However, in the more likely scenario, the pilot may have actually produced an overall saving equivalent to £36.90 per resident per week, or nearly £250,000 per annum.

The principal savings related to avoided hospital admissions, closely followed by avoided transfers to nursing homes. Savings due to early discharges from hospital were lower but appeared to offer the potential for increase. The benefit of early detection of illness was difficult to quantify in monetary terms, but may add to savings in the longer term.

Some data was collected at a time when early challenges of implementation were still apparent. This may well have inhibited some cost-saving activities and led to a sizeable underestimation of the model's true potential over a longer period of time. Similarly, the cost of the pilot service might have been overestimated because the original set-up offered potential for refinement without major loss in effectiveness.

With these points in mind, the researchers conclude that the key remaining question is whether any final increased cost associated with the pilot (if indeed any exists) is worthwhile in terms of the following additional benefits:

- promoting long-term quality of life and quality of care of residents;
- providing a firm foundation for 'new role' workforce development.

About the study

The research was carried out by Deidre Wild and Sara Nelson of the Faculty of Health and Life Sciences, University of the West of England, Bristol, with Ala Szczepura, of Warwick Medical School, University of Warwick.

The overall research design brought together multiple sources of evidence. Focus groups and interviews were conducted with key stakeholders, nursing team members, care home managers, care staff, and resident groups. An economic evaluation was included to estimate the cost of the model and the cost savings it achieved.

For further information

This summary brings together the findings from two interim reports from the evaluation:

The In Reach Model Described from the Perspectives of Stakeholders, Home Managers, Care Staff, and the In Reach Team (May 2007), available from: deidre.wild@uwe.ac.uk.

and

Audit of In-Reach Team (IRT): Activity, Costs, Benefits & Impacts on Long-Term Care (September 2007), available from: ala.szczepura@warwick.ac.uk

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