South London Care Home Pioneer Programme – Cohort 4

Service Improvement Poster Booklet

2022

Health Innovation Network South London

My home life England

Enhancing Dining Experience for Care Home Residents

South London Care Home Pioneer Programme

Abena Davis-Antwi; Highfield House, Croydon, London, UK

Aim

To develop a plan to enhance the current dining experience for care home residents in order to optimise good hydration, nutrition, inclusion, and health and wellbeing.

Background

Highfield House specialises in neurorehabilitation for residents with complex neurological conditions. Many of the residents have a tracheostomy and ventilator in place to support them with breathing and they require assistance with all activities of their daily living.

I chose to be part of the Pioneer Programme because my manager suggested it would be a great experience for me, meeting other healthcare providers, networking, and learning from each other's experiences.

Introduction

Good mealtime care may improve quality of life for residents and reduce hospital admissions. In addition, eating and drinking are fundamental human activities, with significant social and emotional associations. The psychosocial aspect of mealtimes is important and may impact on food intake and quality of life (Faraday et al., 2021). Therefore, I chose to embark on this service improvement project to enhance the dining experience for residents in my home to improve not just their nutritional and hydrational intake, but also as a means of enhancing their mood, by establishing a conducive environment that facilitates social interaction and inclusion. This is to try to get some normality and excitement back post the COVID-19 pandemic. I believe that it will therefore optimise resident's mental wellbeing.

Some of the changes that I am hoping to make include residents having their meals in the dining area instead of their rooms, and making the dining area more presentable. The philosophy of Highfield House has always been about resident-centred care, therefore enabling residents to have a good dining experience tailored to their preference is paramount. As in most cultures, food and mealtimes play a pivotal part of the residents' lives. This project is important to me because I believe a good dining experience can enhance social interaction, build a sense of community, and increase nutritional intake. A good dining experience should be regarded as meaningful as any other activity in the home.

Faraday J, Abley C, Beyer F, Exley C, Moynihan P, Patterson JM. How do we provide good mealtime care for people with dementia living in care homes? A systematic review of carer-resident interactions. Dementia (London). 2021 Nov;20(8):3006-3031. doi: 10.1177/14713012211002041. Epub 2021 Apr 7. PMID: 33827279; PMCID: PMC8679165.

Aims and Objectives

1. To develop and establish a dining experience that is tailored to residents' preference and brings about fulfilment and satisfaction.
2. To improve nutritional intake.
3. To enhance and promote social interaction among residents.

Method

I collected baseline data on the residents' views of their current dining experience using a survey. This survey was given to nine of our residents and the completion of the survey took four weeks with the assistance of two carers. The result of this survey was collated and shared with the kitchen head chef. Unfortunately, the changes based on the survey were not able to be implemented in the timeframe, due to funding, so we have not yet been able to measure the change. We plan to do another survey asking the same questions after the changes have been implemented to see how it affects the residents.

Results

The results from the survey were mixed, where many of the residents that took part were fairly satisfied with their current experience, however, would like some adaptations or improvement to increase their overall experience.

Out of the 9 residents who took part in the survey, 2 residents, both on different floors, expressed that they were happy with their current experience by scoring 8 out of 10. Another two residents scored their current experience a 6 (good), one resident scored a 5, another scoring 4 and one resident who seems to be more dissatisfied with the current dining experience scored 2.

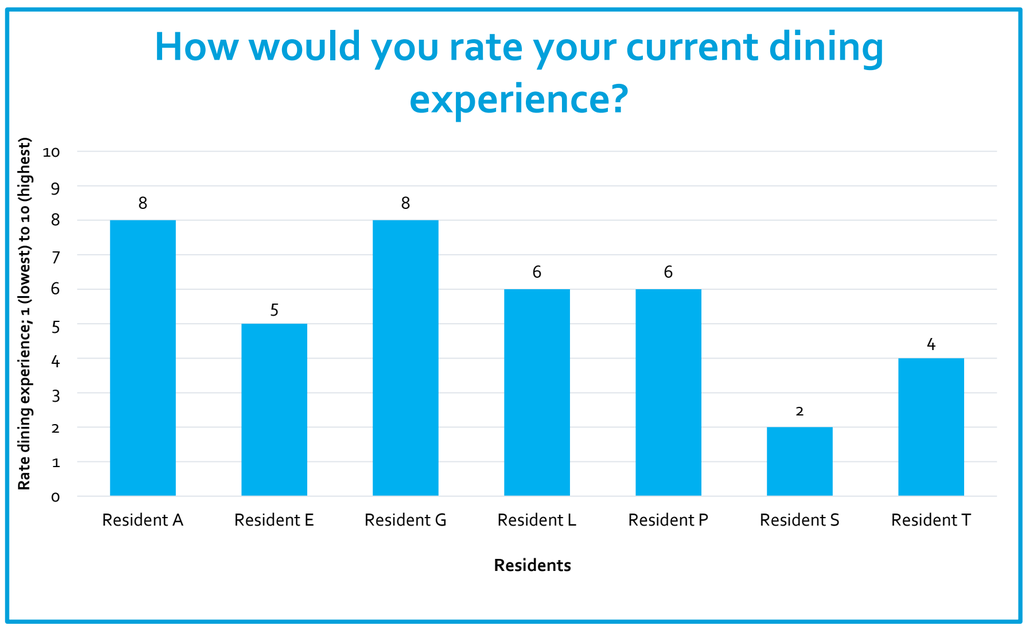
The residents that were not entirely satisfied with their current experience, were given the opportunity to explain their views and what changes they would like to see. The result of the survey was shared with my manager, who advised to have a meeting with the kitchen head chef to discuss the results. The meeting was successful as we both shared the same concerns and had ideas to improve the whole experience for the residents.

Following discussions with the head chef, we have come up with some proposals pending funding approval. This involves purchasing new tableware, centre pieces, assorted condiments, making menus more visual (Restaurant style) and redesigning the dining room with the help of the residents.

Conclusion

At the point of writing, I have not yet been able to finish my service improvement project due to the delays in the funding process. However, I have discussed my plans with the residents who appear very pleased and are really looking forward to the changes.

The plan next is to review fluid balance charts, food diaries, mood/ABC charts and use a post survey to measure the overall success of the project and the impact it makes to the residents. A comparison between the pre and post surveys will also be used as a way of measuring the success of the changes.



A graph showing the scores that eight residents gave their current dining experience from 1 (lowest) to 10 (highest).

Current dining experience set up

What I hoped to achieve when the service improvement has taken place

Health Innovation Network South London

My home life England

highfield house fairliehealthcare

Engaging Residents in Social Activities

South London Care Home Pioneer Programme

Ade Michael; Manon House, Croydon, London, UK

Aim

To provide meaningful social engagement for service users within the home, in order to create a social bond/network, promote service users' cultural beliefs, support them with daily living, reduce social-isolation, and reduce the frequency of anti-social behaviour.

Background

I am a CQC Registered Manager at Manon House in Croydon, which is a residential care home for male service users with mental health needs. Our residents have different mental health diagnoses from different boroughs in London.

I chose to take part in the Pioneer Programme to acquire more knowledge and experience as tools to provide a better service for our service users, support and impact my fellow colleagues, share my experiences with others in the programme and to seek their collective ideas and opinions in solving similar challenges faced.

I also wanted the benefit of group networking for future references and support for service improvement, because the CQC rated the home as 'Require Improvement'.

Introduction

Manon House has male service users that are mostly independent hence the challenges of anti-social behaviour and complaints from our neighbours. Some of our residents play musical instruments and tend to entertain neighbours within the community with their skills, however, it does not agree with some of the neighbours who think that it is anti-social.

I proposed to have a multi-activity room that residents could use to exhibit their skills and would serve as a rehearsal and recording room for their musical instruments. The aim of this was to reduce or stop the frequency of anti-social behaviour complaints received from our neighbours and to support service users with showcasing their skills in the comfort of their homes without any challenges.

We were hoping to use the project as a form of meaningful engagement for service users, creating a relaxing and welcoming learning environment, promoting their cultural beliefs, and creating a social bond among residents, staff members, families, and carers.

Method

We set up consistent community meetings with service users to discuss the project and seek their opinion. This meant that they could understand what is expected of them, gather what they would like to see and their choice of musical instrument. We started finding out the cost of the selected equipment and instrument, using eBay, Amazon, and Facebook marketplace. The staff and residents started a project proposal to be presented to the leadership team of the organisation and we invited senior management to our home to do the presentation through a musical rendition from our residents and staff.

We proposed a multi-cultural event to hold in our home with the aim to invite our residents' families, carers, neighbours, residents from neighbouring homes, our senior management, executives, CMHT, local authorities, and commissioners. The preparations were all done within 3 months with support from our residents, CMHT, our directors, staff, and some friends.

We used observational techniques to understand the impact of the change, by seeing how residents reacted and responded to the multi-cultural event, and we counted the number of complaints due to anti-social behaviour from the neighbours.

Results

Our proposed multi-activity room was approved and funded by our organisation. The residents were very cooperative with planning the event, sharing their opinion with staff, and feeding back on the progress through resident and staff community meetings.

We held our multi-cultural event in July 2022, with a special musical rendition from our residents, staff, senior management, and invited guests. It was a wonderful experience for our residents and a post-event meeting was held with staff and residents. Residents expressed their appreciation of the change, and the chance to display their skills. One resident, who tends to self-isolate, sang to the amazement of everyone and he has been fully engaging with different activities ever since. The complaints of anti-social behaviour reduced to the minimal and the event has been replicated in other homes of our organisation.

We also had a CQC inspection recently, and the project was part of what earned the service a 'Good' rating by CQC as against its former 'Require Improvement' rating. This suggests the positive impact that the multi-cultural event in July 2022 had on our residents, staff, and neighbours.

Conclusion

To improve residents' internal social engagement, a multi-function room for the use of residents was created. This has become a rehearsal ground for most of our residents who have musical instrument skills. The room has also become our entertainment ground as residents would sit there to reflect, enjoy movie night, entertain, and we are currently running a musical instrument learning session and singing class. It has led to improved resident satisfaction, social engagement, and reduced anti-social behaviour complaints. It has also helped with our CQC rating.

We faced the challenge of working within our financial budget; trying to get the best deals on equipment slowed the project down. Another challenge was persuading the residents to attend the meeting at the initial stage, encouraging the resident to spend more time within the unit to avoid further anti-social behaviour complaints from the neighbours, having to sort each residents' cultural delicacies, attires, and agreeing on priorities and options.

If I did this project again, I would explore other areas of residents' interests as well i.e., arts, painting, DJ, etc.

The Pioneer Programme has really widened my scope. It has opened my eyes to so many opportunities to support our residents better, impact staff and identify my level of resilience and how I can manage myself to maintain and render better service to the residents and staff. It has increased my self-confidence and has given me the opportunity to share my experience and acquire more knowledge from other peoples' experiences too. It has improved my listening skills and I can proudly say I have learnt a lot of solution finding, problem solving and conflict resolution through this programme more than I ever had before.

Health Innovation Network South London

My home life England

Cognithan

Improving Communication between Staff during Handovers

South London Care Home Pioneer Programme

Akinwale Oyelekan; Windmill Lodge Care Home, Lambeth, London, UK

Aim

To develop an effective handover in order to improve communication within the care home, and reduce handover-related complaints from February 2022 to September 2022.

Background

I have worked in the care sector for over 18 years. I have extensive experience in managing care homes for older people, including people who live with dementia, learning/physical disabilities, and mental health conditions.

Windmill Lodge Care Home provides dementia and residential care across 93 en-suite bedrooms, with communal living and dining areas.

Our home has a truly warm and inclusive feel, and is at the heart of our community, which we're very proud of. I chose to take part in the Pioneer Programme, so I can improve my home and make a difference to the care our residents receive.

Introduction

This project focused on improving handover and communication between staff in the care home. Prior to the project, we identified gaps in handovers where information had not been shared between team members from one shift to another, which had resulted in complaints.

The aim of the project was to review our handover process so that it was more effective, there was better communication, and more appropriate and concise information was passed on within the team.

We improved the handover process by creating guidelines and checklists for agency staff, making changes to how we record information for handovers, introducing 24-hour reporting, and implementing an induction checklist. We also used the SMART aim to review our progress and achievements.

Method

We have a system which we use to report complaints and incidents, called Radar. I looked at the last 18 complaints recorded on Radar between February 2022 to September 2022 and 10 of those were due to gaps in handovers. For example, a gap in a handover had led to a medication error.

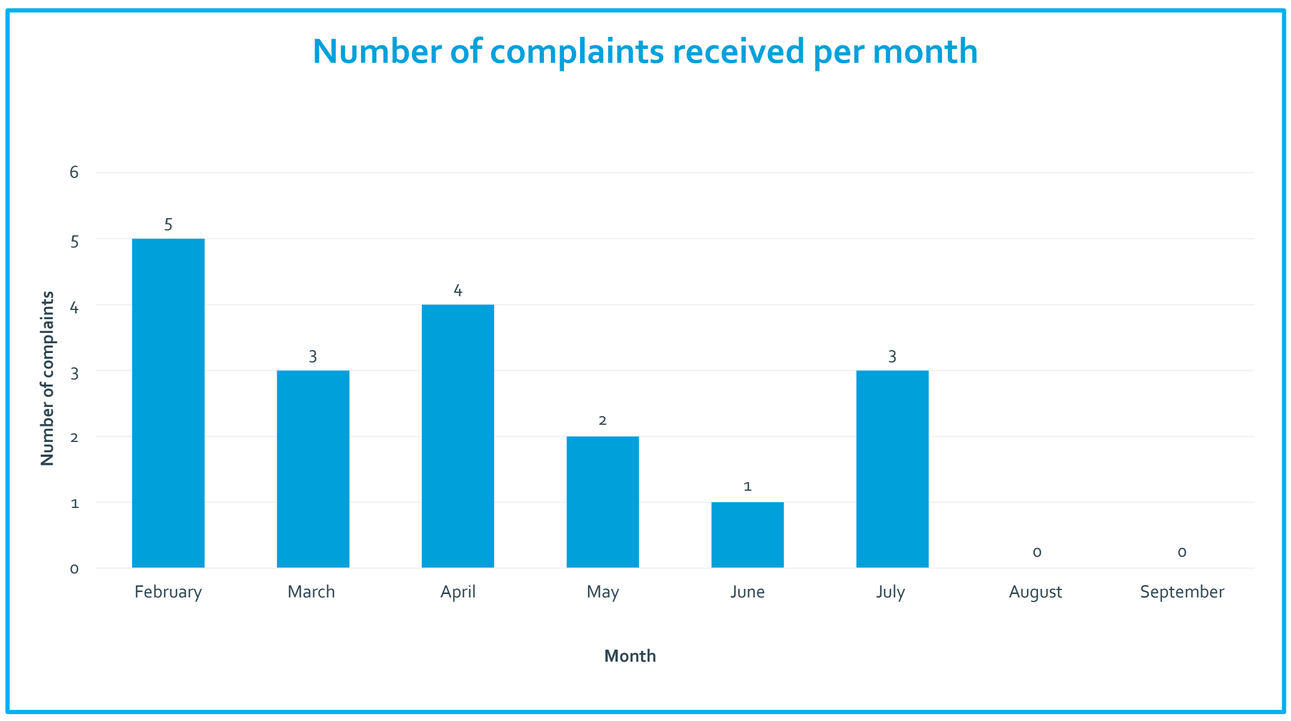
Therefore, we decided to measure the number of complaints received related to handovers per month over the course of 8 months, with the changes taking place in May. I informed the team about the project idea and what we planned to achieve. The team agreed that it was good idea as it was evident that there were gaps in our handovers. The team suggested also reviewing agency handovers as part of the project.

Results

As you can see in the graph, the number of complaints related to handovers decreased over the 8 months from February 2022 to September 2022. In February we had 5 Complaints, 3 in March, 4 in April, with the introduction of this change occurring in May. The complaints then reduced to 2 in May, 1 in June, and then went to 3 in July. Changes were made to the process, and we had zero handover related complaints in August and September.

This shows that the changes in handover were successful and positive, because the complaints reduced after the intervention was implemented in May, and positive feedback increased over this time.

We will continue to implement this service plan and review our handover processes. This is so that we can adapt to any changes, and put structures in place for new team members to be inducted into the new handover processes.



The graph above illustrates the complaints we had in the home relating to lack of thorough handover.

Conclusion

We were able to reduce our complaints from an average of 3 a month, from February to July, to 0 in August and September. Our positive feedback increased as did the resident satisfaction. We faced challenges as it was difficult to get all team members to follow the process initially. When we implemented the new handover system, we discovered that some team members had not been following the process thoroughly. We recognised that the consultation process could be extended to give the team enough time to process the change.

The Pioneer Programme has helped me improve my listening skills, learn how to get the team involved, and use their feedback to improve the home.

Health Innovation Network South London

My home life England

Excelcare Belong with us

Managing Deterioration in our Residents

South London Care Home Pioneer Programme

Anjuman Amboorallee, Dalemead Care Home, Richmond-upon-Thames, London, UK

Aim

To improve managing deterioration in our residents, thereby reducing unnecessary hospital admissions and pressure on local hospitals.

Background

I work for Dalemead Care Home, a family run organisation, based in East Twickenham. The home is registered for Elderly Mentally Infirm although we do care for residents who do not have any mental health issues as well. The home is divided into four units and I try to support everyone from staff, residents, the multi-disciplinary team and the next of kin.

I've always had a passion for care of the elderly which started from when I used to care for my parents. I have worked my way up from a health care assistant to a deputy manager. Throughout my experience in care, I have learned to manage diversity and inclusion. I have built a positive relationship with my team and the multi-disciplinary team. I believe care is delivered from the heart and there is always room for improvement.

Introduction

When I first started at the home, I noted there was a panic culture when residents had any health-related issues, falls etc. There was always a conflict between ensuring the residents received the right support and medical treatment, with an unnecessary call out for the ambulance service and dealing with safeguarding issues. When I was offered the opportunity for the Pioneer's Programme, I thought this would be a good source of information and knowledge.

The change project I introduced was to support better management of deterioration in our residents and to reduce unnecessary hospital admissions. This would also reduce the distress experienced by residents, family members, and staff caused by long waits at A&E. This would also support our residents to have more in-house care and treatment in a familiar environment as many of our residents live with dementia. Because of the panic culture of sending the residents to hospital before making a fair assessment and judgement, it was important to make this change. This was also a supportive way to educate staff and to build their confidence in sourcing the appropriate support from the appropriate services. It helped staff develop their awareness in recognising soft signs of deterioration and knowing when to raise the alarm.

The aims were to build staff confidence and reduce panic culture, upskill and educate staff, and support staff to request help and support from the appropriate health professionals. The aim was also to encourage staff to work jointly with the multi-disciplinary team, support staff to take responsibility and make good use of the resources available, and support escalation and response pathways to reduce unnecessary hospital admissions.

Method

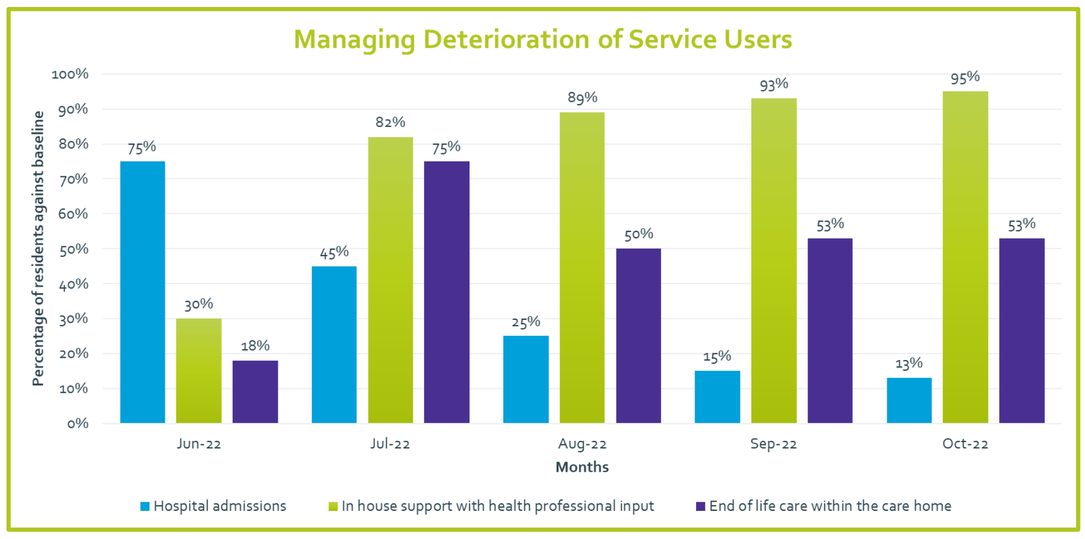
The service improvement project was to use RESTORE2™, a managing deterioration tool, to upskill staff, support staff to take physical observations, calculate NEWS2 scores and be aware of how to respond to a deteriorating resident. The project was introduced in a team meeting, where we discussed the importance of the project as well as changes in our approach in dealing with deterioration in our residents. We allocated tasks and decided who would be responsible and set time scales. We had meetings every two weeks and collected regular feedback from the team, as well as relatives. We collected data on residents' baselines and observations such as temperature, pulse, blood pressure and saturation twice a day. We sought help from the multi-disciplinary team such as the GP, care home support team, district nurses, tissue viability nurses and others. All interventions were recorded on the residents' health records and discussed with the next of kin. We also collected data on hospital admissions, in-house support with healthcare professional input, and End-of-Life care.

Results

The service improvement project ran from June 2022 to September 2022. During this period, hospital admissions steadily dropped from 75% to 45% to 25%, showing that deterioration was being managed better within the home. In addition, there was an increase in in-house support provided to residents, with input and support provided by relevant health professionals.

As the staff were more confident and had developed a good understanding of recognising soft signs in our residents, we supported most of our residents' end of life, hence promoting a dignified death with the family members present and the support of the palliative care team and hospice. This was increased from 18% to 75% then to 50% which shows the support provided by the team enabled the residents to receive the appropriate care and treatment at the care home. The results also suggest that staff felt more confident in carrying out observations as the project progressed. They continuously developed their skills and knew when to raise the alarm. Staff improved their knowledge regarding which health professional to get help from and dealt with situations in a calm and reassuring manner. The change was positive and successful, supporting everyone involved. The residents were cared and treated in a familiar environment which alleviated their feelings of anxiety and agitation. The residents were more relaxed, and the next of kin were reassured and felt supported by the team.

It was very interesting to see how the care team grew and developed their skills. Regular feedback was gathered and data showed continuous improvement. We aim to continue with the service improvement project, maintain what we've achieved, and improve further.



This graph shows the data collected on hospital admissions, in-house support with health professional input, and End-of-Life care within the care home.

Conclusion

The project was challenging since most of our residents live with dementia which make it difficult to carry out a justified assessment especially in the case of falls, because some of them are not able to tell if they are in pain. Because of this, we used observations results, soft signs and changes in behaviour as well as using the Abbey Pain Scale Assessment . This can be especially challenging over a weekend when we can't easily ask the GP for advice. It can also be challenging when next of kin don't agree with certain treatment options which would assist the home in treating the resident. Being a residential home, we rely on the multi-disciplinary team for advice and support. There is limited access to this service over the weekend and bank holidays.

However, within the last six months, working more closely with the team, there have been improvements to how we manage deterioration. The staff felt confident not only to communicate with the senior team, but also the multi-disciplinary team. I can see a well equipped and educated team, which has changed the way we deal with difficult situations. The panic culture is well reduced as staff have developed their skills and have a more confident approach. It has had a positive impact on staff morale and the residents too as they tend to sense when staff feel panicked.

The support from the Health Innovation Network and My Home Life England have boosted my confidence, skills, and knowledge in working jointly with the multi-disciplinary team. The Pioneer Programme empowered me to exercise my duty of care and leadership while supporting a positive professional working relationship. I aim to maintain the good practice and to continue to grow and develop together with my team.

Health Innovation Network South London

My home life England

Dalemead Care Home

Improving Documentation and Care Delivery in the Home

South London Care Home Pioneer Programme

Antonio De Assis; Nightingale Hammerson, Wandsworth, London, UK

Aim

To promote positive interactions between service users and staff and increase the documentation of interactions.

Background

I am the manager for Wohl household at Nightingale House Care Home, in Wandsworth, South London. The home has an average of 110 service users divided into 6 households. Nightingale has 180 years history of care excellence. There are approximately 20 beds with services users living with High Dementia Needs.

I chose to take part in the Pioneer Programme to improve the standards of care within the home and encourage the production of clear data e.g., documentation.

Introduction

The project aim was to improve the documentation for all daily interactions between staff and service users within the home, and therefore build stronger relationships between service users and care home staff. I was also hoping to improve audit results, because communication, emotional support and activities were highlighted as 'very low'.

Clear documentation is the key for quality and improvement and all interactions with the service users must be clearly documented. It is important to build a strong connection and bond between service users and members of staff to make a positive impact on their overall physical, emotional, and mental health.

Method

An audit was completed on the Person Centred System (PCS), with the total written minutes that members of staff spend with service users per month. I calculated the total minutes of interactions within three specified areas: emotional support, communication, and activities that members of staff spend with service users during April 2022. This was done to establish a baseline prior to the start of the service improvement project.

After this, every 30 days a new audit was completed, reviewing the same interactions, with all members of staff from Wohl household, over a period of 6 months.

Results

The baseline audit showed that there was poor documentation regarding the 3 specific interactions being measured with members of staff and service users.

All members of staff were educated on how to complete all the documentation to reflect their interactions with our service users from April 2022 - May 2022.

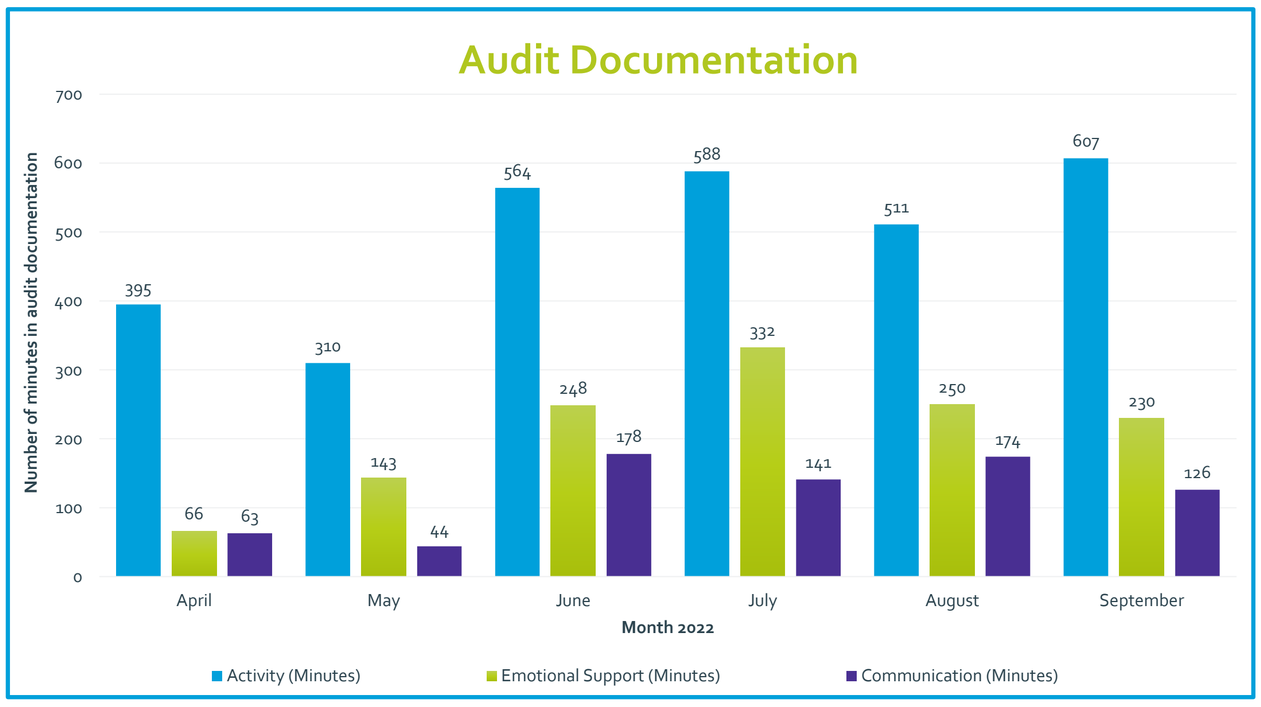
Every opportunity was used to reinforce this idea of the importance of documentation, through daily handovers, supervisions, informal chats, and weekly staff meetings.

The changes started immediately when the audit results were shared with the team at Wohl household. All the results were easily accessible on PCS and we could demonstrate what we were doing for our service users on a daily basis. I introduced the project as an opportunity for us to improve the quality-of-care delivered to our service users.

A new culture was created in the household to motivate members of staff to document their interaction with our service users, and to understand the importance of interactions to improve staff – service user relationships. We were and will continue to monitor the progress on a weekly basis and give feedback to staff to continue the improvement.

The data in the graph shows that there was a large improvement in documentation of activities, emotional support, and communication with members of staff and service users. The graph shows an overall improvement and increase in the number of minutes staff spent with service users in all areas that were measured.

This shows that staff and service users were building on their relationships which will improve delivery of care overall.



The graph shows the number of minutes that staff spend with service users doing activities, giving emotional support, and communicating over a period of 6 months from April to September 2022.

Conclusion

There was a large improvement in documentation and number of minutes spent with service users through activities, emotional support, and communication. This shows an improvement of the care delivered to our service users. The staff were more motivated with the positive feedback and better results. The challenges with the delivery of this project were the shortages of staff, and the need to be very proactive. We also needed to make sure agency staff were well trained to use the electronic devices to document everything that is done with the service users. A shortage of electronic devices for all staff was also a concern, however new devices have been requested. The Pioneer Programme helped me to be more focused and think more analytically on a specific area of improvement in our household. Also, it has taught me how to implement approaches to engage our members of staff in different service improvement projects.

Health Innovation Network South London

My home life England

nightingale hammerson

Implementation of the electronic Medication Administration Record (eMAR) system

South London Care Home Pioneer Programme

Clemence Muchingaguyo, Nightingale House, Wandsworth, London, UK

Aim

To introduce and implement an electronic Medication Administration Record system to Nightingale House care home by the end of December 2022, to reduce medication errors.

Background

I am a registered manager and head of Nursing at Nightingale house. I have been with the organisation for over 10 years. I initially joined as a registered nurse, and then progressed to becoming a manager, to head of nursing and registered manager. Nightingale House is a charity organisation providing care and accommodation to older adults from the Jewish community. Nightingale has a capacity to accommodate up to 215 residents on one site. I chose the Pioneer Programme in order to improve my personal development and to introduce service improvement into my home, to reduce medication errors by introducing a market leading, safe, and efficient medication administration record system.

Introduction

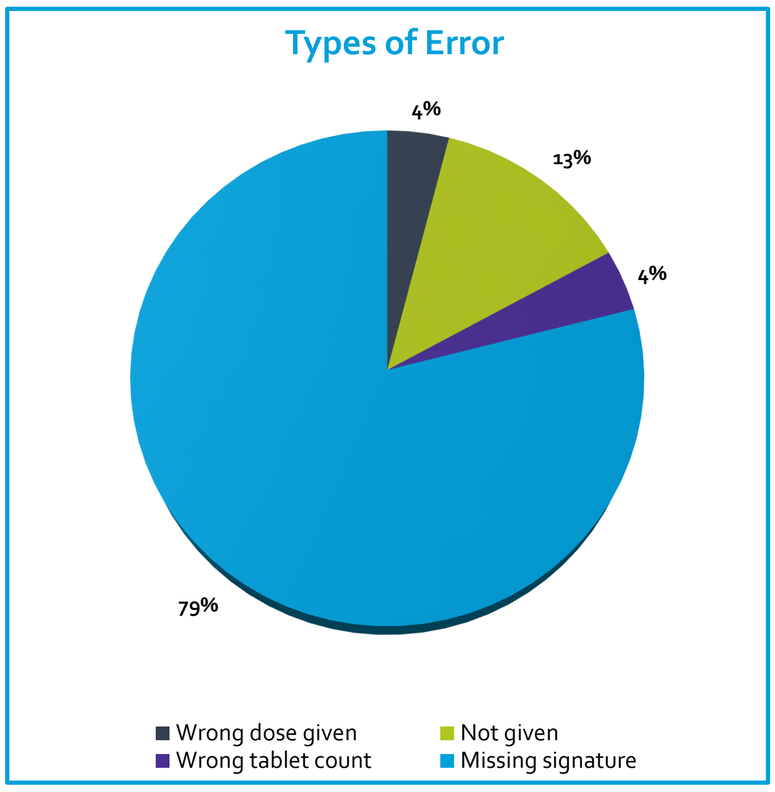
For the period I have been with Nightingale House, we have used paper MARcharts which is an outdated and time-consuming process. My service improvement project is to introduce electronic Medication Administration Record System (eMAR), an alternative to paper-based MARcharts, and a market-leading electronic medicines management system proven to increase resident safety and improve care home efficiency. The system digitally links care homes to GP's and pharmacy dispensing systems. The idea of moving to an electronic record system is seen as the most effective way forward. The proposal is to completely switch from paper-based medication administration to electronic system by the end of 2022. The Pioneer Programme made it possible to consider undertaking this project, helping me to think about the potential benefits. Listening to fellow pioneers who are using electronic systems was reassuring as I got to hear how they implemented it in their homes. The recurrence of medication errors and time taken in auditing can be significantly reduced. Medication administration falls under safety from regulators inspections, so it is important for the home to ensure consistent safe medication standards are maintained. The objectives will be to have evidence-based improvement in the service to our residents, to prevent medication errors, reduce time spent on paper administration audits and prevent potential safeguarding risks which may arise due to preventable errors.

Method

I collected a sample of data for medication errors that were reported and documented over a period of three months using our internal and current auditing system. We currently do weekly and monthly medication audits across the home. The data I collected was drawn from four key areas of reported errors namely;

1) Missing signatures - dose given but not signed for
2) Medication not given at all
3) Wrong dose given, and
4) Wrong tablet count

Audit data is collected on paper templates, with weekly audits capturing 25% of MARcharts, so all residents charts are audited by the end of the month. Having considered this for a service improvement project, I initially consulted with the Director of Care laying out my proposal and reasons for wanting to do this project. Their support meant I could approach Trustees for funding approval. I interviewed 13 team members who are trained and qualified to administer medication and also do audits. I asked similar questions to each individual on what challenges they faced when using the current medication system and what they thought about changing to eMAR. I collected the data over a period of 3 months and included day and night staff who administer medications. I also engaged with our technician and advanced nurse prescriber. For residents I did a short questionnaire and only asked residents from the residential and nursing households. 11 out of 16 residents were willing to contribute when approached with a questionnaire. Households for residents living with dementia were not included. During the period of data collection, I arranged to visit a fellow Pioneer at a home in Sutton who had already implemented the same system. The visit facilitated an opportunity for benchmarking as I was able to see the system in operation, ask questions and seek potential challenges. I also took advice from a Pioneer mentor to request for a demo from the company I intended to get software from. It was helpful as the company agreed to provide an hour's demonstration of how the software works.



This chart shows the percentage of different medication errors by category in a three month period.

Results

Whilst I haven't yet introduced eMAR, plans are still in place for implementation early in 2023. Through the research carried out, it was evident that paper-based medication administration records are open to a lot of flaws and potential safety issues. It has no defence for human errors which can potentially lead to significant harm. The measurements for the sample period as summarised in the graph below showed 79% of the errors were of missing signatures, 13% errors were medication not given, 4% were wrong dose given and 4% were the wrong tablet count. My participation in a demonstration from the supplier of the software proved that the errors we incurred in the three-month period would have been completely avoided. The system would not allow a staff member to give the wrong medication or close the system without signing for dispensed medication. It also automatically deducts dispensed and administered medication and generates an audit while populating data for stock ordering. The positive aspects of the project were, and continues to be, fully backed by Trustees and the funding was approved. The demonstration from the supplier resolved all queries, and as part of the service agreement, the supplier will provide tech support and training to team members. In the past 3 years, Nightingale has been going paperless, and medication administration records is one of the few areas in need of going paperless. There are more advantages to having eMAR than the status quo and this hugely helps to encourage change amongst the team. The system links directly with the pharmacy so both the home and the pharmacy can see orders placed and delivered, and alerts are automatically raised where stock is running low. Despite the last-minute drawback from the pharmacy, the project will continue to be implemented in the first quarter of 2023. Consultations with potential pharmacies that are already working with the software are underway. Due to the size of the home, I plan to introduce the project on a phased programme starting with residential households to allow for close monitoring of the implementation. The current increased pharmacy presence in households can be reduced as the majority of the work will be carried out electronically.

Conclusions

The project makes a very strong business case. eMAR is now widely used in care homes across the country and internationally. The system digitally links care homes to GP's and pharmacy dispensing systems and the tech company is UK-based. The main success of this project is that most of the groundwork research has been completed, including projected costings. Meetings with potential pharmacies are already planned for. We are already using a software for care notes that can easily integrate with eMAR with no extra charges. Consultation with other suppliers did not include demonstration to give a fair comparison with the selected pharmacy. I feel confident with the progress so far although the project is not fully implemented. The Pioneer Programme has helped me personally develop as a leader, and has supported me to use benchmarking skills, network with other care home managers and share knowledge on best practice in care. Most importantly, the Health innovation Network team helped to bring about understanding of service improvement and how to introduce change.

Challenges

The main challenges were that the current pharmacy had agreed in principle to adopt the software and continue with our supplier. During the final stages of discussion, the regional support manager decided to pull out and declined to take on the software, because they would not give up their preferred software. We had to give two months of notice to terminate the current contract and start looking for another pharmacy supply. Due to the large size of the home, full implementation would be risky and demands a lot of resources, so the implementation will have to be phased. eMAR is not fool-proof as it relies on human input for stock, if a wrong figure is used the audit will be incorrect.

Health Innovation Network South London

My home life England

nightingale hammerson

Enhancing Job Satisfaction through Improving Induction Processes for New Starters within the Service

South London Care Home Pioneer Programme
Daniel Nkwantabisa; Stanley Park Road, Sutton, London, UK

Aim
To improve induction processes for new starters, so they can gain confidence and satisfaction in their new roles.

Background
I am the Service Manager of Stanley Park Road residential home.

Stanley Park Road is a residential service that offers individualised accommodation for individuals with learning disabilities, autism, and complex needs and challenging behaviours.

Our residents are male and range between ages 23 to 45 years.

Introduction
A new starter's first impressions of an organisation have a significant impact on their integration and interaction within the team. Induction is an opportunity for an organisation to welcome their new starters, help them settle in, and ensure they have the knowledge and support they need to perform their role. For an employer, an effective induction may also affect employee turnover and increase job satisfaction.

Over the years, induction processes within the service have been confined to providing new starters with large volumes of the company's policies and support plans to read rather than involving and encouraging them to interact with residents at the beginning of their employment.

The aim of this project is to help new starters feel welcomed and integrated within the team, and empower them to perform their job role to a high standard.

Method
Qualitative data methodologies (questionnaires and focus groups) were employed to gather information for the project.

The focus groups were used because they allow for more in-depth answers and discussion. Questionnaires were targeted at both experienced staff and new starters to find out their opinion and their experience with the induction process within the service and how this affected their confidence and job satisfaction.

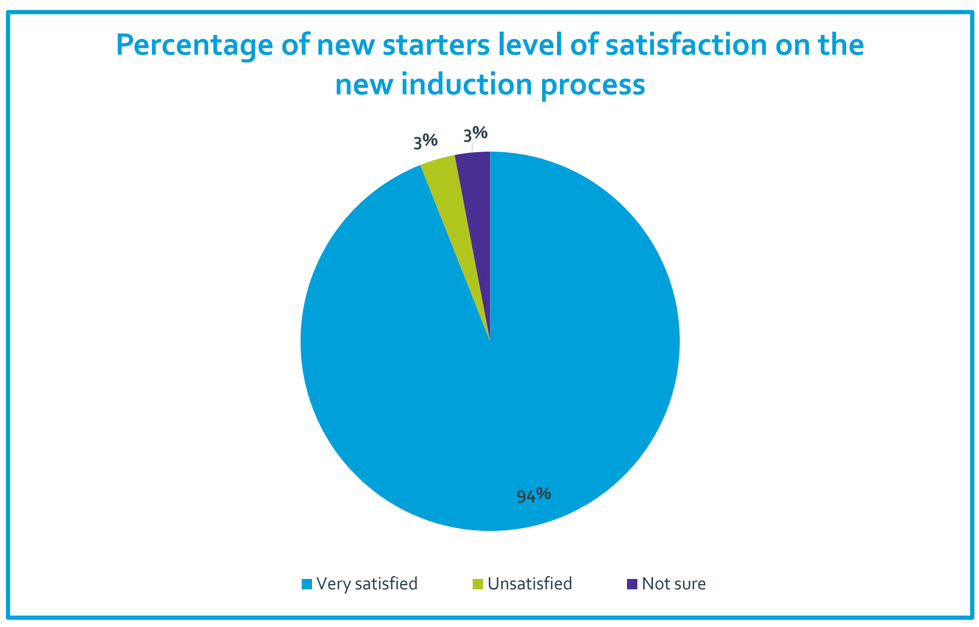
Separate focus groups were organised for experienced staff and the new starters on separate days to identify the different experiences each group had and to ensure both groups didn't influence one another.

The data collection and the organisation of the group discussions and questionnaires took approximately three and a half weeks.

Results
The first 3 days of the new induction were organised as a webinar where HR, recruitment, and senior management introduced new starters to the company's policies and values and conducted a Q&A open forum. After day 3, new starters went to their employed services to meet and be welcomed by the manager and the support team before arranging for a 'buddy' to shadow on service-specific job roles.

Data analysis from the questionnaires showed that 94% of new starters were impressed with the new induction processes that were introduced by the company. All the experienced staff and new starters agreed with the introduction of a new induction process. 95% of new starters reported that the process had made them confident enough to face the challenges of supporting the residents within the home.

The questionnaires also showed that 65% of the experienced staff who have been with the company for 2 years or more, reported that they did not have a good induction process, but rather learnt a lot independently and with experience.



New starters level of satisfaction of the new induction process.

Conclusion
The main success of this project has been being able to identify the problems of induction processes within the service and the company. Data collection tools of both focus groups and questionnaires were used to collect experiences and opinions of the experienced staff. From the results, induction processes were updated and adopted so that they are more service-specific, and this has been successful.

The challenges of this project have been time constraint as due to shortages of staff on shift and it was difficult to organise separate focus groups for both new starters and the experienced staff. This project has given me the experience to liaise more with senior management to discuss other issues that need improving within the service.

Health Innovation Network South London
My home life England
consensus

Improving Induction Processes for New Staff

South London Care Home Pioneer Programme

Jacqueline Perdrix; Brook House Nursing Home, Greenwich, London, UK

Aim

To improve the induction process for new staff by making sure everyone has a 1:1 with a senior manager before they begin their role.

Background

I am a care home manager at Brook House Nursing Home, in Greenwich. It is a 74-bedded home, with 3 services: younger persons unit (14-beds), conventional nursing (30-beds), and dementia (30-beds).

I chose to take part in the Pioneer Programme to take time out to help my peers, share best practices and solve challenges with each other to make me a better leader and manager.

Method

To measure the success of the change made, we used observation to understand the difference in the new staff's attitude to their role, and experience after the improved new staff induction. This was done over the span of April to September, a period of 6 months.

The people engaged in this project were the new staff, the deputy manager, and care home manager, the clinical lead, residents, and relatives.

We also went on to understand what could further be improved to make the induction process more effective which is discussed in the results section.

Introduction

A good staff induction is incredibly important because it will mean better resident care if staff feel more comfortable in their role and welcomed into the organisation. It can enable new starters to share the vision and ethos of the care home, and it will lead to improved communication with residents, other colleagues, and relatives. In addition, working with the company proudly and being accountable for what you do can bring a sense of belonging and identity to the staff member. Finally, an effective staff induction can provide accurate information about the role, what is expected of new staff, and a good understanding of their role and responsibilities to settle well into their post.

It was identified that the induction process had been lacking. Previously, after staff were interviewed and offered the position, all compliances, including DBS, references, and signing contracts, were carried out by the admin team, and new staff were then asked to complete the eLearning mandatory training. However, it was recognised that further support from existing staff would be beneficial to support the new starter in their role.

The change that I wanted to make, (and what the first induction day should include), was for the new staff to meet with the deputy manager, who would welcome them and brief them about the service, what is expected of them, and what to avoid. They would also reinforce the importance of asking questions, raising concerns, safeguarding, and giving feedback. The new member of staff would then have a 'Health & Safety' induction with the Facility Team and would be allocated to a senior carer/nurse to shadow, who would further support their induction.

This would also allow the deputy manager to further develop their leadership and mentoring skills, and strengthen relationships within the workplace.

Results

Before this change was implemented in April 2022, no staff had been inducted via a 1:1 with the deputy manager. Since the new induction process was introduced, 20 carers and nurses, and 7 staff from the admin team have been inducted. From observations, we can see that staff are a lot happier and feel more comfortable in their roles, and there has been improved communication between staff. New staff have felt more able and comfortable to speak to their senior colleagues, which shows an improvement in communication regarding raising concerns and issues.

A testimony from one of the new health care assistants about the new staff induction is shown here, which is a favourable response to the new induction process and demonstrates the positive impact of the change:

> "I had my induction from 28/06/22 - 01/07/22; it was very productive and educative. I've learnt a lot of personal care, interpersonal relationships, Health and Safety issues, and customer communication skills, among other things. My manager, deputy manager unit manager, and my colleagues were very supportive. I've learnt new skills for life, and it made me a better person in performing my role, supporting my clients, and the team at large. I am still learning and hoping to know more."

Conclusion

The main improvement made was an introduction of a 1:1 with the deputy manager when new staff arrive, to help staff feel more welcome, so they can better understand their role and responsibilities, and make senior management more approachable for help and support when raising concerns. The results showed that this has made a big difference to staff attitudes, feeling more comfortable in the home, and improving relationships between residents and carers. It has increased job satisfaction and encouraged staff retention. It has also identified challenges and training needs, the need for ongoing professional development, and improvement in mentorship and leadership skills. The clinical lead, and Head of Care on the Board are also involved in trying to improve staff induction.

However, more could be done. It was discussed what could be done to effectively improve the induction process and the service improvement project. The below changes would encourage feedback from both parties to explain their experience during the induction process, improve communication between staff, and therefore quality of care, and increase accountability:

- Development programme for leadership and mentoring for the Nurses and Senior Carers.
- A trainer has been contacted and I am designing a bespoke training for staff.
- Develop a structured induction "task list" for the mentor and the new staff, which will be a reminder of what must be covered in the induction process.
- Implement a new staff survey
- Implement a survey for residents about the new staff to understand their experience
- Preparation with senior management to carry out the 1:1 by briefing them on the new staff member and review interview notes

The challenges of the project included some initial resistance to change, time constraints to make sure 1:1's were happening, and changing culture and mindset.

Health Innovation Network South London

My home life England

BONDCARE

Enhancing the Meal Experience for Service Users

South London Care Home Pioneer Programme

Lee Ndou-Sidija; Heron View Care Home, Croydon, London, UK

Aim

To provide healthy nutritional options for Service Users, to increase nutritional intake, and enhance their mealtime experience over a period of three months.

Background

I am a Registered Manager of a specialist care home. Heron View is a 35-bedded care home in Croydon, that specialises in supporting Service Users with acquired brain injuries and challenging behaviours.

As part of my role, it is my responsibility to ensure the staff that I manage provide the best possible care. Therefore, I chose to take part in the Pioneer Programme to gain skills and experience in implementing innovative practices in my care home.

Introduction

Food is a critical element for providing the right support and care to our Service Users. It is imperative that Service Users are provided nutritious healthy meals daily. Healthy meals promote healing, healthy skin, good digestive health, and prevention of weight loss. Therefore, I wanted to ensure that the service promoted meal choices by involving Service Users through their participation and/or representation from their loved ones.

I chose this project as Service Users had provided feedback that they were not satisfied with mealtimes. This was also evidenced by the amount of food that was being wasted from meals.

The aims and objectives were:

- To provide culturally appropriate meals for Service Users
- To ensure specific needs of our service users were catered for (e.g. vegans, vegetarians, and halal)
- To ensure, where appropriate, food and fluid charts were completed as soon as possible after the resident had finished eating.

Method

Thirty-five Service Users and relatives were interviewed through Service User of the Day questionnaires, which involved reviewing care plans for the Service User and completing their dietary forms. Feedback and staff observations was collected during mealtimes. Food and fluid charts were also reviewed to check if these were completed correctly or not.

Baseline data was collected over a period of 2 months, from July 2022 to September 2022. An initial meeting with the chef was held to get them on board. Feedback collected from Service Users indicated that culturally appropriate meal choices were limited so the menu was amended to accommodate residents' specific needs e.g. vegan, vegetarian, and halal. A weekly menu was introduced, with the option of giving suggestions for the following week. Alternatives were offered if a Service User didn't like anything on the menu. Feedback indicated that breakfast required improvements, so a full English and a continental breakfast was introduced on Thursdays and Saturdays respectively. Staff fed back that Service Users would ask for biscuits at night time, so a 'Night Bite' menu was introduced. To allow for a more inclusive and social dining experience, the dining areas were rearranged to allow more Service Users to sit around a single table. Monthly Malnutrition Universal Screening Tool (MUST) scores were analysed to notice any changes in BMI.

Results

MUST scores indicated that 15 Service Users had increased weight into a healthy BMI (increase of average 3kgs after 3 months). Six Service Users refused to have their weight checked, but there were no visible signs of weight loss. Seven Service Users weight had decreased (1-2kg), but there was no impact on BMI. Six Service Users were being supported by the Speech and Language Team for Obesity.

Feedback was collected again through the Service User of the Day which revealed that the introduction of a weekly and night-bite menu were well received, and residents reported to be happier with the service. All fluid charts were audited to ensure that they were signed off at the end of each shift.

The rearrangement of the dining areas prompted Service Users, who used to sit in the armchairs at mealtimes to come to the table; thereby promoting more social interactions that normally did not take place. Some Service Users now regularly sit together and converse at mealtimes as well as in other social settings, where in the past this would not have happened. Staff are also supporting the Service Users by making sure that their food is presented well and is well-portioned.

Staff have been contributing to the renewed peaceful and social atmosphere at mealtimes by providing soft background music, helping to calm the atmosphere. Staff have also been engaging Service Users in conversation and making use of encouraging language to support those who have difficulty eating. The management team 'stop the clock' during mealtimes to observe how the meals are being served and presented, helping to support the eating experience.

HERON VIEW WEEKLY MENU

WEEK... FROM ..... TO .....

SERVICE USER'S MENU

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
BREAKFAST	Assorted Cereal, Porridge, Toast and Juice	Assorted Cereal, Porridge, Toast and Juice	Assorted Cereal, Porridge, Toast and Juice	Full English Breakfast	Assorted Cereal, Porridge, Toast and Juice	Continental Breakfast	Assorted Cereal, Porridge, Toast and Juice
LUNCH	Beef Stew served with Rice and vegetables	Shepherd's Pie served with Vegetables And salad	Meat and veggie pie. Served with salad	Jerk Chicken and Jollof Rice served with mixed leaves salad	Fish and Chips with tartar sauce	Chicken Stew with Roasted Potatoes	Roast Chicken, potatoes, and green beans
DINNER	Soup of the day, chef's choice	Jacket Potatoes Cheese, tuna, and salad	Omelette Salads	Sausages Bakes beans and Salads	Chef Choice	Bangers and Mash with green pies	Soup of the day.

Dessert options: yoghurt, cake, rice pudding, trifle, ice cream, apple crumble

PLEASE NOTE: **ALL MEALS ARE SERVED WITH VEGETARIAN/VEGAN OPTIONS AND HALAL MEAT**

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
NIGHT BITES	Sandwiches Biscuits, Hot and Cold drinks	Sandwiches Biscuits, Hot and Cold drinks	Sandwiches Biscuits, Hot and Cold drinks	Sandwiches Biscuits, Hot and Cold drinks	Sandwiches Biscuits, Hot and Cold drinks	Sandwiches Biscuits, Hot and Cold drinks	Sandwiches Biscuits, Hot and Cold drinks
SERVICE USER'S SUGGESTION							

Introduction of weekly menu to cater to SU's specific needs.

Introduction of night bite menu and space for SU's suggestions for next week's menu

Conclusion

The service improvement project aimed at enhancing the meal time experience of Service Users was successful, as we saw 15 of our residents gain weight, and all the residents were happier with the service they experienced. The success of the project lay with the whole team's involvement and approach. There has been an increase in Service User engagement during mealtimes.

In future, staff on kitchen duty will take the following day's menu around, discuss it with Service Users, and collect the next day's requirements before 4pm each day. This information will then be delivered to the kitchen where the catering team can use the information to plan the volume of food required. If food is being transported to different units, it will be done in a mobile and heated trolley. The catering team will monitor food service throughout the home to ensure quality food presentation.

This Pioneer Programme has helped me to utilise resources available to me, and has increased my engagement with staff, using the skills gained during the programme.

Health Innovation Network South London

My home life England

BramleyHealth Caring Minds

Enhancing the Resident Experience

South London Care Home Pioneer Programme

Libby Mathew, Meyer House Care Home, Bexley, London, UK

Aim

To create a bistro/cafe area to enhance the resident experience, and improve their wellbeing.

Background

I work as a Registered Manager at Meyer House Care Home in Bexley, part of Nellsar Ltd. It has been one year since I took on the role and since then everyday has been a learning phase. We have 28 residents in our care, mostly general nursing, and palliative nursing.

I joined the Pioneer Programme because I wanted to learn how to become a better manager, improve my care home experience, and learn to communicate better with my staff and residents. It was also recommended by my Learning and Development Manager. The requirement to complete a service improvement project is also a part of my Level 5 Leadership and Apprentice course.

Introduction

My overall aim is to help residents feel happy and content by providing them with a space where they can spend time with family and friends in a café setting and reminisce with memories of being together. My service improvement project is therefore to create a Bistro in the extended area of our lounge which can be used by the families and our residents. An on-site café setting is especially helpful for those residents who are unable to go out of the care home to spend time with their loved ones. In the Bistro setting, they have a private space within which to enjoy tea and coffee. The space used to be called Nana's Parlour and a few years ago it was used as a space for our residents who were able to walk, to chat and watch television.

However, as most of our residents now have nursing needs and mobility assistance, the area stopped being used in this way. Whilst our formal lounge is being refurbished, I have decided to use the space to create the Bistro setting, ensuring it is mobility-aids friendly, so that all our residents can enjoy that relaxed feeling of sitting in a café. This is important to our care home as this will enable some of our residents to get the real feeling of sitting in a coffee shop and enjoying time with their friends and family. This would have a positive impact on both residents and relatives happiness, and health and wellbeing.

Method

There has not been any data collection as part of the project as it has not yet been launched. However, I will collect resident and their relatives views before the café opens.

I liaised with several different stakeholders, shown below, when developing this idea and planning the work that needed to be done. Information was collected and ideas shared with these different stakeholders over the period of a month:

- Residents - they loved the idea and seemed very excited. I approached residents who were able to express themselves individually, and had discussions with them.
- Family - discussed the project with them and asked for their opinions and contributions.
- Senior Managers and Deputy Manager
- Operations Manager – regarding project planning and finances.

Results

I have not been able to complete the project as planned yet, so therefore the café has not been opened. This means I have not yet been able to collect any results.

The delays have been caused by a number of reasons:

- Issues with the roof and leaks
- Flooring that needed to be changed
- Delays with getting approval for the work to undertaken

Despite the delays I am continuing with the service improvement project. I feel confident from the stakeholder engagement that the project will be successful. I believe it will be meaningful to residents and family members, and will reap many benefits once it is complete.

Conclusions

I am very satisfied with how the initial stages of the project have developed from a planning and stakeholder engagement point of view.

Although there have been delays in opening the café, I am now at the point of being ready to complete the internal decorations. I am in the process of getting bistro tables and chairs and some posters to give the space a bistro-feel. I am also looking to buy some modern lighting to improve the feel of the space.

Although the space isn't yet ready, I feel there has been success in getting the roof repaired and new flooring laid, because this has been a major financial expense. One of the other challenges I've experienced is in relation to purchasing a coffee machine which is of good quality, but also not too complex and difficult to use.

My next steps beyond this service improvement project will be to focus on improving the dining experience for our residents.

Through the Pioneer Programme, I have learnt to be more patient, to know where I need to step back, and give space for others to express themselves. I have also learnt how to use questions to offer solutions.

Health Innovation Network South London
My home life England
Nellsar Care Homes Est.1988 TOP 20 CARE HOME GROUP carehome.co.uk

The Journey - Supporting Residents Walking with Purpose

South London Care Home Pioneer Programme

Natasha Leslie, Coloma Court Care Home, Bromley, London, UK

Aim

To improve the experience and quality of life for residents in the care home who are living with dementia and experiencing sundowning, through introducing activities.

Background

I have been working in the health and social care sector for over 20 years. I've worked in the community with the elderly as a palliative care training manager and as a care home manager.

Coloma Court Care Home is located in West Wickham, Bromley and part of the Healthcare Management Trust. We have 62 beds and have residents of mixed abilities. The home has a Christian ethos but welcomes people of all faiths, as well as people who do not consider themselves to be religious.

I decided to take part in the Pioneer Programme as I felt it would benefit me as a person to improve my skills to support the staff, residents and families in the home.

Introduction

The area of improvement was around meeting the residents' needs. Residents were exhibiting 'sundowning', which resulted in some of them walking with purpose between the hours of four and five o'clock. During this time, residents might become agitated and more confused than normal. The area of improvement which we called 'The Journey' was to try to assist residents by introducing activities and nutrition which they were missing out on because they were walking with purpose.

The Service Improvement project was discussed with all senior colleagues in the home, and it was decided that because 'walking with purpose' contributed to falls and weight loss, it was an important area to focus on. We created an area for residents to take part in activities designed specifically for them, and meals were also given in this area. Residents were encouraged to assist with laying tables and where they were able, to serve themselves and others. This activity helped to keep these residents engaged and encourage social interaction.

The activities that were introduced were based on information obtained from residents, their life histories, and their relatives. It was also important to gather information from all the different teams, including the lifestyle and catering team as part of the project. Gathering all this information helped us to understand the residents' needs, why they were walking with purpose, where they were trying to get to, what their individual triggers were when they are distressed, and why they were not taking on fluids and nutrition.

Method

We developed a simple project plan that detailed the tasks that needed to be completed, who it was assigned to, start and end dates, and the task status. Data collected was from the care team, GP, relatives and from life histories. Baseline data was collected by senior carers from general observations to weight, their likes and dislikes, and information on RESTORE2™, which is a deterioration management tool. The data was collected over 8 weeks via meetings, information sessions, emails and using existing systems in place. This enabled us to deliver a more personalised experience to the residents.

Results

Staff noticed the impact on residents as residents have been more settled in the evenings, less walking with purpose, and sleeping better etc. Residents also experienced less incidents such as falls. Residents enjoyed the scheme and spoke about their experiences when they returned from the dedicated space. For residents and their relatives, the dedicated space also helped develop better relationships as families were able to use the space for their visits between the hours of 16.00-18.00. Residents were more engaged during visits rather than walking off, and families were also able to join in on the activities, which provided stimulation and conversation.

We will continue to add new residents to the project and remove those who are settled, if possible, provided this does not cause any disruption to the resident. We would also like to look at other activities which could be provided outside of the home.

Conclusion

We feel the project has been a success. Residents feel more supported and engaged in the activities, and there have been less incidents in the care home particularly around falls and behaviours of concern. This has had a knock-on effect on the number of calls to 999 or 111 services. Residents have also expressed looking forward to coming to the sessions and we're looking at how we can expand this further. Going forward, the home is hoping to review medication and weight to see if the dedicated space has had an impact on these areas. The Pioneer Programme gave me the information and support I needed to conduct this project. The Action Learning Sets were also very good. All of the participants in my group were able to talk to each other, find out what was going on in each other's homes, and take advice from each other. This enabled me to carry out the practices back in the home.

I have also been very pleased to present on this programme of work at a University College London Partners (UCLP) Care Homes Safety Network event in September 2022, which focussed on service improvement. I also participated in a video that was recorded and presented at the 16th UK Dementia Congress in November 2022, as part of a presentation on the Pioneer Programme, 'Using leadership development to improve the quality of care provided to persons living with dementia'.

Images of residents enjoying the new dedicated space, the Journey.

Health Innovation Network South London
My home life England
HMT CARE HOMES | COLOMA COURT

Dementia Workshop for Families

South London Care Home Pioneer Programme

Nicola Orme, Burrows House Residential Care Home, Bromley, London, UK

Aim

To improve the relationship between families and the care home, due to misunderstandings of what dementia is and how we manage that in a Care Home setting.

Background

I have been working in care for over 30 years in one form or another: Orderly, Carer, Senior, Teacher, Trainer, and Deputy Manager at a care home, which is my current role. I have worked at Burrows House Care Home, in Bromley, for 5 years. It is a 54- bedded residential Care Home for frail elderly persons and those living with dementia.

I chose to take part in the Pioneer Programme to improve my management skills, so I can make myself a more effective manager for my home and for my team.

Introduction

My Service Improvement project was a Dementia Workshop for Families to help improve relationships between relatives and our staff. We found that during the COVID-19 pandemic, those who had joined our Burrows House family during lockdown could not see how we worked with their loved ones or visit their relative inside the home. They did not understand how we manage the condition, and this caused some difficulties and a lot of misunderstandings between us.

The aim was that by having a better understanding about dementia and how we work would help minimise these misunderstandings and improve relationships with relatives. This is very important as we try to work as part of a team with our families. Residents who were in the home prior to lockdown had it much easier, as their families had seen with their own eyes how we worked and supported their loved ones, so we did not have as many incidences with these families, but they were still interested in finding out more as well. I spoke to our families during one of the relatives' meetings and asked them if this would be something that they would be interested in attending. I got a very positive response from them, and they looked forward to attending and learning more.

Method

I started to gather my data by polling relatives during the quarterly meetings regarding their thoughts on a Dementia Workshop tailored for families, and most seemed very interested in attending the course. I asked what sort of topics they would like me to cover and what did they feel was important for them to learn. I then began designing the workshop and gathering materials and information for them.

Once the course date was set, I asked the attending families to fill out an evaluation form before the start of the session, so I could gather an idea of how much they knew, if dementia was important to them, and how much they were hoping to gain from the session. During the workshop, there was plenty of debate and questioning, which made for an interesting and informative workshop on dementia. Once the course was completed, I asked them to fill out another evaluation on how effective they felt the training was and how it helped their knowledge, and understanding of dementia. I also asked if they felt it would help them to interact better with their loved ones and if there was anything they felt I missed from the course. The workshop covered the facts and statistics about dementia, the types of dementia, the risk factors, dementia myths, nutrition, how to support people living with dementia, and signposted to useful contacts.

Results

The evaluation that was completed before the workshop showed that families had only basic knowledge of what dementia was, how it affected people, and how it can present itself in an individual. Every person living with dementia presents differently even if they have the same diagnosis.

Families wanted this knowledge so they could better understand how their loved one was doing, what challenges they faced, and how they could help them lead a fuller life. An evaluation was also completed at the end of the workshop which showed greater understanding of the issues and challenges surrounding dementia, and how we manage this in the home. The impact this had on our residents and the families was almost immediate. They now spend much more quality time together in a way that enriches the person living with dementia, and makes the families feel still involved in caring for their loved one. For our staff, the impact has been even greater, as the rate of complaints and misunderstandings has greatly reduced. There is better communication between staff and families, and a general feeling of us all working together as a team for the benefit of our residents.

The residents have also benefited from the workshop as their families now have a better understanding of what they are going through, so are better able to support them, interact with them, and help orientate them better, which has had a knock-on effect to the general feeling of wellbeing in the home.

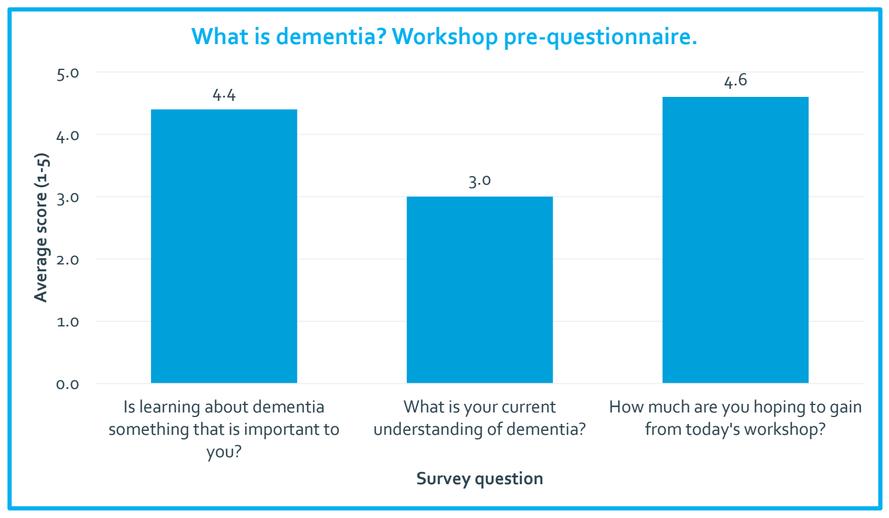
Conclusion

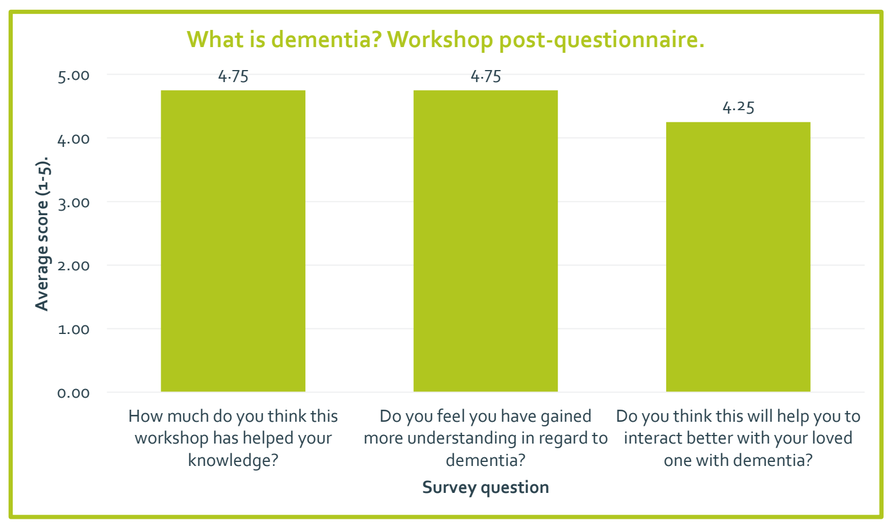
The project was a Dementia Workshop for families of those that live with dementia, to improve the lives and relationships between staff, families, and our residents. The workshop proved to be a great success in improving relationships between staff, families, and residents. We have more interactions from families wanting to be involved in the care of their loved ones, better communication between all, reducing the amounts of complaints and misunderstandings, and a better atmosphere in the home in general.

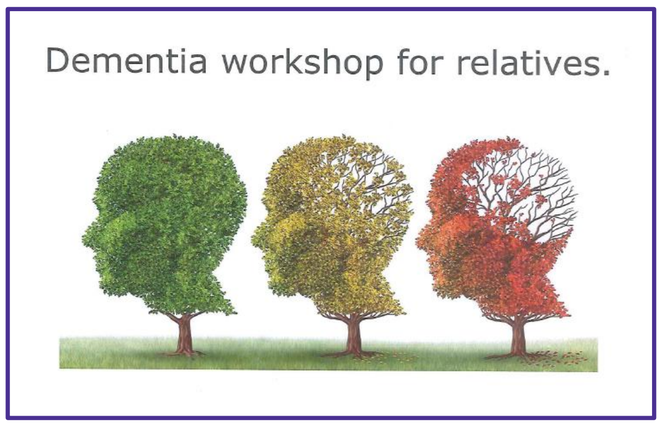
It was a challenge finding the right level to pitch the workshop at, as I didn't want it to be too technical, with a lot of medical jargon. I wanted it to be fun, informative but practical in the way the information was delivered, and the real-life examples were used. It was also a challenge to find the right time to hold the workshop as families have busy lives and families of their own, but we managed to find an appropriate time and all the family was welcome, including children, and grandchildren.

I have improved the workshop since the first session to include more examples of how dementia affects different people in different ways after suggestions made by families after the workshop had finished. With the success of this project, I will now be running it a couple of times a year for new relatives who join the Burrows Family, so they also will get the benefits of better understanding and support with the ongoing care of their loved ones. This will also help maintain a better understanding between the staff and families and enable us to forge a better working relationship going forward.

The Pioneer Programme has helped me become a more effective leader by improving my communications skills, how I talk and react to people talking to me. It has also given me a lot more confidence in myself and my role as Deputy Manager at Burrows House.







Resource pack for the Dementia workshop and evaluation sheets for before and after session/workshop.

Health Innovation Network South London

My home life England

Gold Care Homes
It's what's inside that counts

Improving Dementia Awareness among Care Home Staff

South London Care Home Pioneer Programme

Odeta Svagzdiene; Riverdale Court Care, Bexley, London, UK

Aim

To raise awareness and skills of care staff who work with people living with dementia.

Background

I am a Senior Care Lead with seven year's experience including time spent as a social worker and four years in Health and Social Care.

Riverdale Court Home provides 24-hours Residential Care, including specialist Dementia Care and Respite Care for those who need it.

The home follows the Eden Alternative Philosophy of Care, which enables us to provide the highest standard of care. The main principle of this philosophy is socialisation, where staff encourage social interaction, engagement and work towards the eradication of loneliness and boredom in our residents.

Introduction

As a Senior Care Lead, my mission and vision is to ensure a high quality of service to our service users. To achieve this, there is a need for a strong team with the right skills and knowledge. However, often lack of understanding of dementia amongst the team has a significant impact on the quality of the service we provide. This affects the communication with relatives, the care home rating and feedback.

My project's aims were to minimise communication issues, improve quality of services, and to develop the knowledge and skills of care staff who work with people with dementia.

My project's objectives were to:

- Recognise different types of dementia
- Discuss how dementia affects the person's life, family and society
- Develop effective communication with service users who have dementia
- Develop effective communication with family members about dementia
- Understand ways to respond to people with dementia who have communication difficulties.

Method

Qualitative methods were used. Part of the quality analysis methodology was based on feedback from care workers on their experiences, feedback from service user's families, and the rating of Riverdale Court. Data was collected in three steps over thirty days.

Information was gathered from care workers during morning meetings, and discussions about difficult situations with service users and their families regarding dementia care. Conversations were held with service users' families with regards to dementia and the issues they face with some of the care workers.

Results

We identified that practical issues arose for staff when trying to balance the need for care and safety, with delivery of person-centered care, rather than institutional procedures. We recognised the need to improve communication between care workers and service users' relatives and families. During care home visits, family members sometimes reported feeling unsure about what was happening with their relative and were distressed by the experience of their relative's care. Both relatives and staff needed a greater understanding of dementia and the importance of care tailored to the needs of the individual residents.

Both staff and relatives found conversations about dementia stressful. By recognising the needs of family caregivers of people living with dementia, often called the 'invisible second patients', they can be more involved and informed.

Based on these findings, conversations about dementia were introduced twice per week with staff in morning meetings and information about dementia was provided which led to improved knowledge amongst staff in relation to dementia. Staff started to discuss dementia during every visit by the service users' families. This led to better communication between care workers and service users' families.

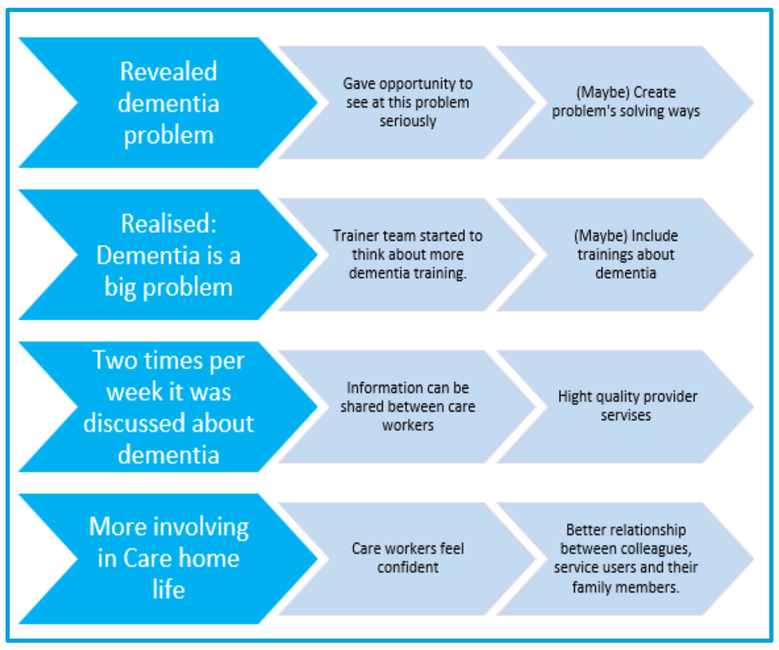
The training team also suggested expanding the dementia training provided to staff.

Conclusion

This project helped to reveal the issues around communication related to dementia care for care home staff and residents' families. It allowed the home to look at the problem thoroughly and supported staff to start thinking about ways to solve the problems. Discussions were held with the training team to include more dementia training for staff in the future. After the project concluded, it was noticed that services for service users improved because of information provided about dementia, and the knowledge of how to treat people with dementia. In the future, care staff can share their experiences about dementia with new colleagues. Afterwards, care staff mentioned that they felt more confident discussing dementia because they could now recognise the different types of dementia and could explain and give examples or suggestions to family members who were experiencing difficulties in communicating with their relatives.

Some of the limitations of the project were the lack of time. Dementia residents and the associated problems couldn't be discussed at every meeting. Other challenges were high staff turnover and limited time for data collection. In future I would involve the management team in the project, prepare informational booklets about dementia to be distributed to all units and prepare informational booklets for new care workers.

The Pioneer Programme gave me an opportunity to improve my leadership skills, including the often complicated skills needed to persuade and influence people, even those over whom I have little direct authority. Also, it helped me to improve my innovative and creative thinking.



Summary of project

Health Innovation Network South London

My home life England

avante care & support 'Everyone Matters'

Oral Health in the Care Home

South London Care Home Pioneer Programme

Pamella Clark-Dayes; Bluegrove Residential Home, Southwark, London, UK

Aim

To improve our residents' oral health, enhancing their health and wellbeing.

Background

I started my career at Bluegrove House as a team leader, and have slowly progressed to eventually becoming the care home manager. I love the work that I do and being a care home manager.

Bluegrove is a residential home with 48 beds that caters for people living with Dementia, and is situated in Bermondsey, Southwark.

I chose to take part in the Pioneer Programme to increase opportunities to network with other managers outside my organisation. I wanted to improve my knowledge on how to be an effective leader, and learn how to support Bluegrove in providing the best possible health outcomes for both its residents and staff members.

Introduction

The aim of my Service Improvement Project was to improve residents' oral health. Oral hygiene is the practice of keeping one's mouth clean and free of disease by regular brushing of the teeth (dental hygiene) and cleaning between the teeth. Residents who suffer from dementia are at greater risk of their oral health deteriorating due to decreased oral health activity, and often not accepting support to maintain good oral health practices. The project was initiated in response to there being insufficient staff knowledge regarding oral health, irregular prompts made by staff to residents to tend to their oral hygiene, and a receipt of feedback from residents and relatives that oral health was not being prioritised.

The objectives were to help to educate staff in best practice methods in maintaining good oral health and the consequences of poor oral health. The increase in knowledge would help to build confidence in providing improved oral care.

The aim was also to support staff to identify signs and symptoms of poor oral health, so that effective support could be offered to residents to prevent discomfort to improve their well-being. Staff members would, as a result, be able to recognise when a resident was not eating for reasons such as a loose denture or a painful tooth.

Method

Staff members, residents, carers and relatives were involved in the project. The project was measured by evaluating staff members knowledge when developing oral care plans for residents.

The project was evaluated via two methods. Staff "oral health care confidence" forms were used to prompt staff to reflect on their oral health education needs, and further discussion and mentoring was implemented where necessary via group supervision. Feedback was simultaneously collected from residents, carers, and relatives when opportunities arose.

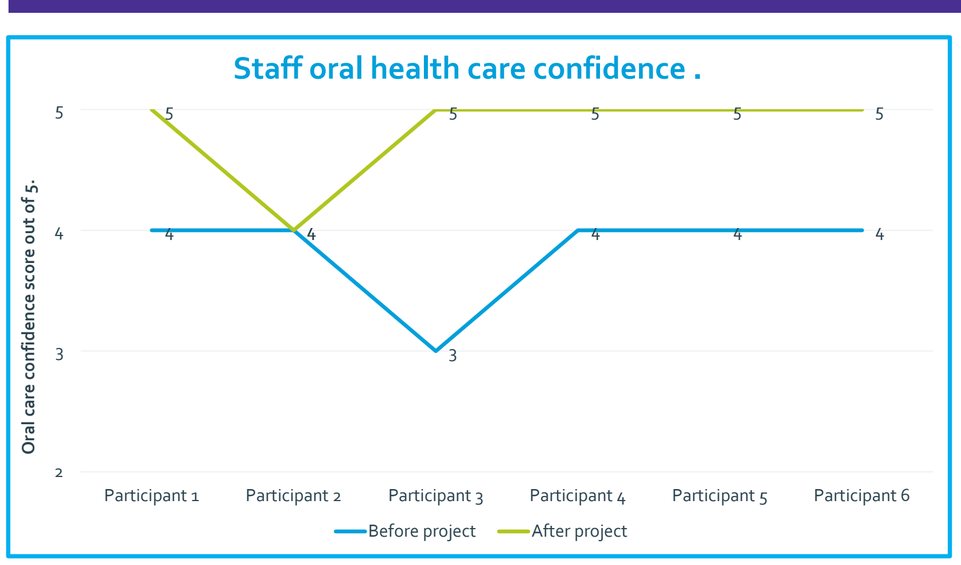
The baseline level of confidence was collected prior to the project commencing. Confidence levels were monitored at various stages of project.

Results

Staff who had low confidence in providing good oral care started to feel more confident through the education they received. When developing thorough care plans, staff members were enhancing their knowledge. "Oral health care confidence" form, completed by staff, allowed the project to identify and target areas where more education was required. A buddy-up system for staff who were less competent, was introduced, to pair them with colleagues who were more competent. This enabled on-going education. As indicated on the graph below, there was an increase in confidence reported in the six oral health care categories in comparison to baseline scores.

Positive feedback from residents and family members was received during carer and family forum meetings. Residents' weight increased or was maintained. There was a reduction in the number of missing dentures reported and there have been no emergency dentist visits.

Bluegrove will continue to implement our oral health service improvement methods moving forward to ensure that residents receive excellent oral care.



The graph provides the monthly average scores prior to and post project implementation of staff member's self-reported confidence in supporting residents with their oral health.

Conclusion

Oral Health is very important to care home residents and people living with dementia. Residents were unable to maintain sufficient levels of oral health without support, with some residents refusing support. As a result, residents would suffer from oral hygiene ailments and report experiences of pain and distress. Carers and relatives would raise concerns as a result.

There were challenges at first as some of the new and already employed staff were not confident in supporting a resident who lacked capacity to tend to their oral hygiene on a daily basis. It was challenging for staff to encourage residents to engage in good oral health practices regularly.

The registered manager completed a survey to understand the level of confidence staff possessed to support residents with their oral health After surveys were conducted, group supervision sessions with all staff were held. Confident members of staff were asked to buddy up with the staff who lacked confidence to conduct oral hygiene checks.

Monthly surveys were carried out and the outcomes were clear – staff members' confidence in their ability to conduct oral health checks and maintenance tasks increased.

Residents and relatives fed back during the home forum meeting that they were happy with the steps the home had taken to support the staff in carrying out oral hygiene checks and maintenance more effectively. This has reduced the number of complaints received.

The Pioneer Programme has helped me significantly to be more confident in speaking without anyone judging. I have learnt from other managers.

Health Innovation Network South London
My home life England
anchor hanover

Improving the Quality of Care Provided to Residents by Supporting Staff to use a Deterioration Management Tool, RESTORE2™

South London Care Home Pioneer Programme

Rajniti Ramnath, Florence Nursing Home, Bromley, London, UK

Aim

To support staff to use the RESTORE2™ tool to recognise a resident's soft signs of deterioration in order to be able to manage deterioration better in the home and thereby reduce hospital lengths of stay and unplanned readmissions to hospital.

Background

I am the Clinical Lead at Florence Nursing Home in Bromley. We have 25 residents in our care home. We have residents who suffer from physical, mental, cognitive, and neurological impairments and have residents under/over 65 years of age. Residents are cared for by our carers and we always have a registered nurse on duty. We work collaboratively with our GP and Bromley social services.

I chose to take part in the Pioneer Programme to enable me to develop my leadership and management skills. I had hoped the programme would help me enhance my role and support me to assess and improve the service we offer. I aspire to become a care home manager in the near future.

Introduction

I chose to focus on Managing Deterioration for my Service Improvement Project, using a tool called RESTORE2™. I chose this topic as I observed some nurses were unable to identify deterioration such as an Urinary Tract Infection, or mini-stroke. Also, I noticed that some nurses were not calling the GP or the Out-of-Hours doctor in good time. They would either wait to speak with me or hand over to the carers, with the GP only being contacted later on.

The aim of the project was to support the nurses and senior staff to recognise when a resident may be physically deteriorating, assess the risk, and respond in a timely manner. Using a tool also has some other benefits, such as improving the quality of observations and monitoring of residents and supporting staff to communicate more effectively with the multi-disciplinary team. This is with the intention of providing the resident with the right care, at the right time, in the right place and with the best possible outcome.

This project would also support the home to possibly reduce inappropriate hospital admission as most residents have treatment plans which describe their preference to be treated within the home and not be taken to hospital. The project will help to promote better outcomes and quality care for residents and ensure they are getting safer care.

Method

Staff attended RESTORE2™ training in June organised by Bromley CCG and also completed their competency assessments in July. NEWS2™ scores were completed for all residents to identify their baseline scoring. By September, staff were detecting deterioration quicker than before the training, with examples of residents who would normally have been admitted, being managed within the home with the primary care paramedic support. The data that was collected was on the number of phone calls that were made to GPs, Out-of-Hours Services, or 999 over the last 6 months. I also looked at residents' records over a 6-month period to see who had been readmitted to hospital after a few months of being discharged from hospital.

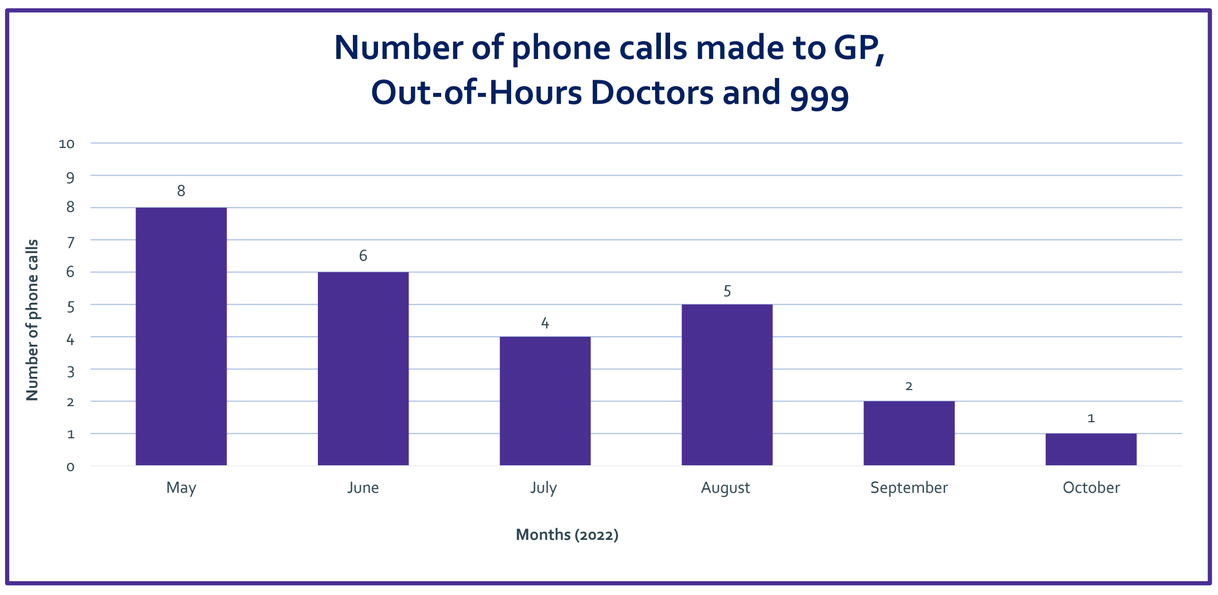
Initially, I discussed the change project with my manager and described how I wanted to improve the quality of the service and implement changes so that we could better meet the residents' needs. The project was proposed to other staff and planned in a clinical meeting. Nursing staff were involved in analysing how many phone calls were made when residents were deteriorating. The manager, registered nurses, and senior carers were all involved in discussions with the GP, to obtain some information from the GP notes related to any hospital admissions. I also consulted the Out-of-Hours Service and London Ambulance Service documents to see what observations, assessment and decisions were recorded.

Results

The data shows that the number of phone calls made to GPs, Out-of-Hours Doctors, and 999 reduced over the 6-month period from May to October 2022, with the training of RESTORE2™ being implemented in July. This could be attributable to the improvements in how the home has been managing deterioration more in-house, and therefore, there has been less of a need to request the support of emergency services or GPs.

This shows the increase in confidence, skills, knowledge and accountability amongst the nurses. The care staff have described feeling proud of being part of this project. The change has been successful, and most care staff agreed there was a need to improve identifying deterioration, reducing hospitalisation, and residents getting the right treatment according to their care plans, their wishes and at times, the decisions made in their best interests by the multi-disciplinary team. By September, staff, management, relatives and the GP were noticing that care staff were responding quicker to deterioration and avoiding hospital admissions.

The service improvement project will be continuing in a digital format. As our residents' care plans, risk assessments, and assessment tools are already digital, we have spoken to the software manager about accessing a digital version of RESTORE2™ rather than continuing with the paper version.



This graph shows the number of phone calls made to GPs, Out-of-Hours Doctors and 999 services and how they reduced over the 6-month period from May to October 2022.

Conclusion

I feel the RESTORE2™ tool is helping health professionals escalate deterioration more quickly once the NEWS2 scores are being calculated. If there is a timely clinical response, this can prevent the resident's health worsening. It is even better if we can offer the right treatment successfully in the care home. I evaluated this project after it was implemented, and analysed the strengths and limitations encountered throughout the project.

Upon reflection, I acknowledged that at times there was some conflict and resistance to change to start using the RESTORE2™ tool. The resistance was partly due to staff workloads, despite us agreeing we wanted to improve the identification of deterioration. However, after clinical training and 1:1 supervision, the nursing team changed their minds and got involved in the service improvement project. Staff recognised that this was in the best interests of residents, and would improve the continuity of care, staff development and provide reassurance to relatives.

RESTORE2™ has supported care staff to become more confident, feel better understood, and to act appropriately according to the residents' care plans and treatment escalation plans. This Pioneer Programme has helped me to reflect on my actions, my role and responsibilities. I met staff from different care homes and we were able to discuss ideas and share our skills, knowledge and experiences.

Health Innovation Network South London

My home life England

Lorven Housing Ltd

Improving Hydration for our Residents

South London Care Home Pioneer Programme

Smithmon Sasi; Devonshire Dementia Care Home & Day Centre,
Kingston-upon- Thames, London, UK

Aim

To reduce UTIs, hospital admissions, and hydration and nutrition risk, by promoting hydration over 12 months using vintage-themed environments in the care home.

Background

We have 30 residents and 5 people who attend our day centre, all of whom are living with dementia. The home has recently been accredited with the National Gold Standards Framework in recognition for our outstanding end-of-life care and our offer of regular activities, including singing, coffee mornings, a virtual dementia experience, and activities that promote wellbeing, friendships and 'moments of magic'.

We offer a free helpline to support people living with dementia in our local community and their carers. Our experience in dementia has made us realise the importance of good hydration to reduce falls, UTIs and ultimately hospitalisation.

Introduction

With the health, wellbeing, and safety of our residents being paramount to our care model, we wanted to improve the levels of hydration in our residents. We chose this project as we felt it aligned with our values, would help us achieve our safety targets and would help reduce the number of residents with UTIs. We recognised that a single solution would not work for all our residents, so we planned a variety of different methods to help our residents drink more fluids.

We introduced

- a 1950s themed Lyons tearoom for afternoon tea
- a "pub" with a countryside setting where residents can enjoy wine, beer, or soft drink in the evening,
- a colourful hydration trolley with vintage cups and dispensing jugs.
- we added a fluid watch system for all residents to measure their fluid intake
- we play games like "snakes and ladders" where the residents get a drink if they climb a ladder or slide down a snake

Method

At the start of the project, all our care staff and other staff members received "hydration training". This included a webinar delivered by our local health and care system and some online training which meant staff were aware of the importance of encouraging fluid intake in our residents. Staff and families have been very supportive of this new suggestion in our model of care.

We had access to data on hospital admissions and numbers of UTIs in our residents from before we started the project and continued to collect this after so we can show any changes. We used data from the 12 months preceding the project and for the 12 months after implementation, which started in October 2021. We recognise that changes in UTIs and admissions will not be wholly due to the project but feel confident that it will have made a significant contribution.

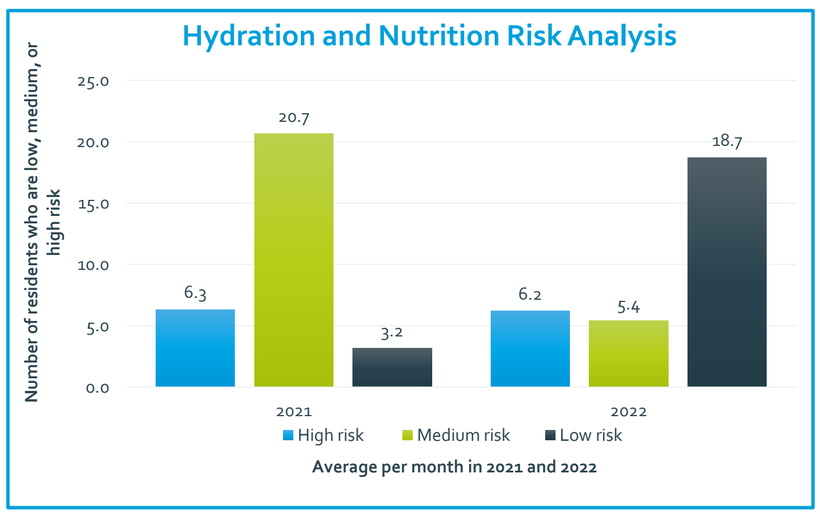
Results

The data collected from the 12 months before and after the implementation has showed an improvement and decrease in the number UTI's and hospital admissions for residents. There was also a shift of the hydration and nutrition risks in residents, shown in the graphs. Although the number of residents who were deemed high risk from hydration and nutrition remained similar, there was a big shift from medium to low risk, showing an improvement in the resident's hydration and nutrition. These results support the suggestion that the project has had a positive change on the residents, and the health and wellbeing of the residents.

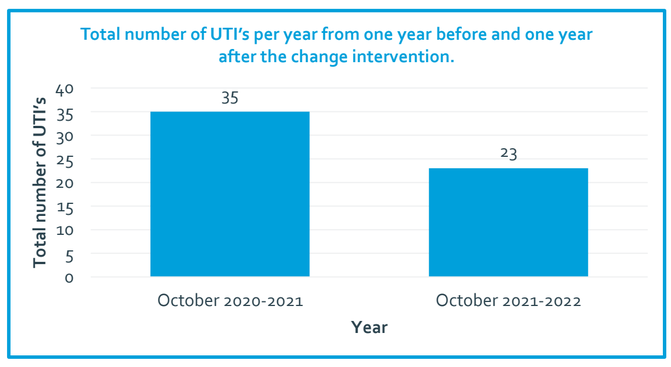
Although we cannot guarantee that the changes made in this service improvement project are the reason for these improvements, we can suggest that it has been a contributing and positive factor, as the activities will have increased the amount of fluid our residents drink every day.

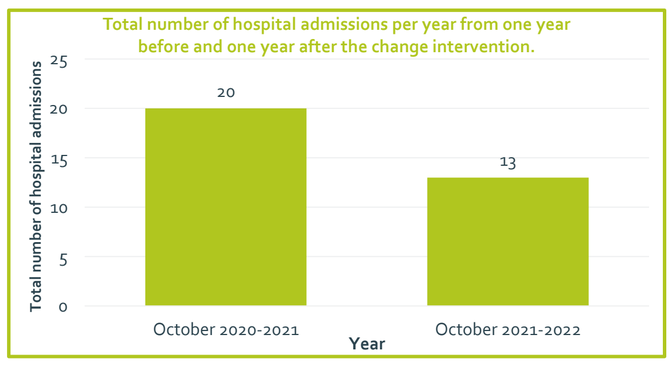
Not all residents have engaged with all the changes, but they have enjoyed different elements of the project. Some enjoy the tearoom and others enjoy going to the pub in the evening. The "hydration station trolley" has been good for those who like to walk with purpose to get a drink as they walk, and some residents enjoy the "Hydration Games".

Staff and relatives have been positive and supportive of the changes, and we plan to continue with all elements of the project. Our next innovation will be to introduce a "snack station" so residents have access to finger foods during the day.



These graphs show the changes in the hydration and nutrition risks, UTI's and hospital admissions for residents in the year before and after the intervention was introduced.





Conclusion

We introduced a suite of interventions to improve the hydration of our residents and day centre attendees to help them drink more fluids. The changes made were well received by residents, relatives, and staff, and the number of hospital admissions, and UTIs have decreased, and there has been a shift from medium to low hydration and nutrition risk, so we plan to continue. Our director was very supportive of the project and was happy to fund the creation of the Tea Room, Pub and Hydration Station trolley. It was difficult and time-consuming to source the vintage equipment to create the right atmosphere. We recognise that the data on UTIs and admissions cannot be directly attributed to this project, but we were keen to avoid over medicalising and intensifying the environment for our residents with intrusive measurement of fluid intake. Carrying out this service improvement project has motivated the team to investigate other areas to improve the care and safety of our residents and continue to develop our services. We'd like to raise our glass (of water) to this project, for inspiring positive change!

Health Innovation Network South London

My home life England

Devonshire Dementia Care
DEVONSHIRE
DEMENTIA CARE HOME & DAY CENTRE

Improving the End-of-Life Care Provided to Residents

South London Care Home Pioneer Programme

Sophie Dogui, St. Peter's Residence, Lambeth, London, UK

Aim

To reduce unnecessary hospital admissions of end-of-life residents to one by the end of September 2022

Background

I am the Clinical Lead at St. Peter's Residence, an older person's home in Vauxhall, with an average population age of 87. St. Peter's Residence is part of Little Sisters of the Poor, a congregation of religious sisters founded by Jeanne Jugan in 1841. The Little Sisters mission is to serve God by caring for the elderly. The congregation now care for the needs of the elderly in 39 countries spread across 5 continents around the globe. St. Peter's Residence comprises 1 nursing and 3 residential units. There are 11 independent living facilities and a 56-bedded residential home.

I signed up for the Pioneer Programme to improve my leadership skills and with the support of my team, innovate in the way we care for our residents and communicate with each other, because it is paramount to delivering outstanding care. I also liked the idea of meeting people in a similar role to me, so that we were able to share our experiences and empower each other throughout the course and beyond.

Introduction

Residents at St. Peter's live with chronic conditions, dementia, and multiple comorbidities. A small proportion of residents are under the management of the palliative care team. My service improvement project was to improve the end-of-life care for residents at St. Peter's by introducing a new process to help manage residents in this phase of life, by referring them to palliative care rather than emergency services thereby avoiding unnecessary hospital admissions.

Prior to this project, 3 out of 4 palliative care residents were sent to hospital when their conditions deteriorated, rather than liaising with the palliative care team and GP to review their health needs. The change that was implemented was to work closely with the palliative care team, dietitian, physiotherapist, and GP to review and plan the care of all St. Peter's residents. The aim was to enable the lead carers and nurses to work together and carry out weekly meetings to discuss residents whose health was deteriorating and palliative residents. On admission of new residents, an integral part of the initial assessment is to identify if there is a PEACE (Proactive Elderly Advance CarE) document in place or if there is a need to discuss advance care planning with residents and relatives. Many residents have made it clear that they do not wish to receive invasive treatment if their prognosis is poor.

This project is important because there were multiple admissions to A&E where the resident was discharged the same or next day, with no active treatment prescribed. This suggests the admission was unnecessary and these have an impact on a resident's health and wellbeing and also puts pressure on our acute services.

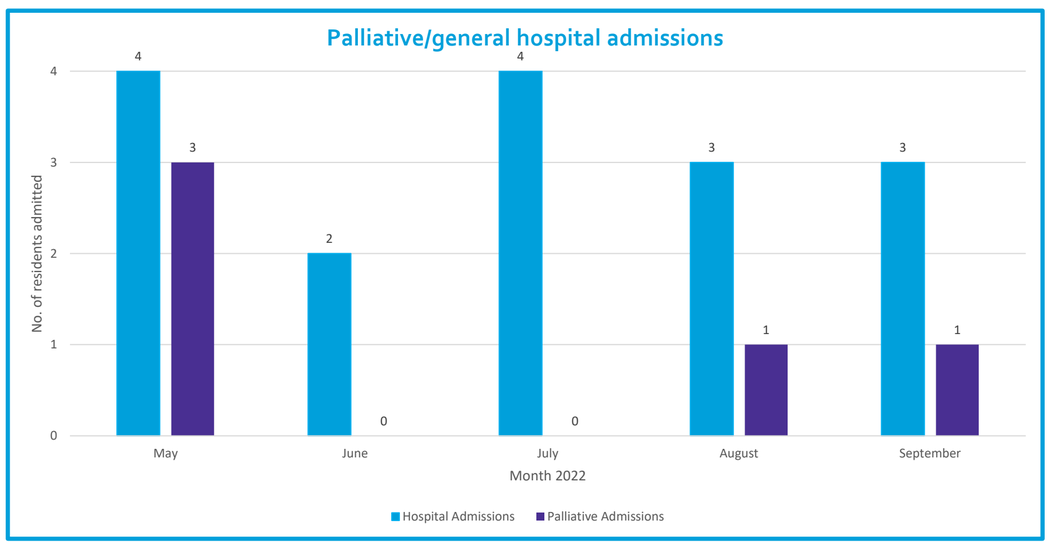
Method

The project was implemented over a period of five months. Data was collected on the number of hospital admissions before the implementation of the project, and over the project period. We also reviewed the overall number of hospital admissions as compared to admissions of palliative residents. Meetings were held with residents, relatives, carers, and the nursing team to involve them in the project.

Feedback from relatives and staff was received over the course of the project. We assessed and monitored the care of palliative care residents daily and liaised with the multi-disciplinary team. The multi-disciplinary team comprised of the GP, the At Home Team, the Palliative Care Team, dieticians, and physiotherapists, who all reviewed the care plans. Carers monitored the residents' health and reported any changes. Nurses assessed the residents and escalated to GPs when they felt a review was needed to determine if a palliative care referral was required. For residents already under palliative care, staff monitored any possible signs of deterioration and liaised with the palliative care team. The criteria to remain on palliative care is strict, therefore if residents are not actively dying and their symptoms are under control, they are discharged from palliative care.

Results

We compared the number of hospital admissions of palliative care residents to the total number of residents admitted to hospital over a period of five months. Five residents under palliative care died in the comfort of the care home following the implementation of the palliative care pathway. Prior to this project, 3 out of 4 palliative care residents were sent to hospital when their conditions deteriorated. Since implementing the project, the palliative care admissions were reduced each month to either one or zero. This shows that end-of-life residents were increasingly cared and treated for within the home. The impact was positive for resident's relatives and staff as the care plan of palliative care residents had involved them, their relatives, carers, nurses and the GP. The project was felt to be successful as all of the team provided direct care to the residents that were involved.



Total hospital admissions were compared to palliative hospital admissions.

Conclusions

The improvements were made in the assessment and care planning of dying residents using an end-of-life pathway. Carers are now more aware of the signs and symptoms to look for when caring for palliative care residents and have a better understanding of the dying process.

There were several challenges in this project, listed below:

- The difficulty of having the conversation with relatives about the end-of-life care for their loved one, particularly because relatives can have very different reactions to death depending on their beliefs, attitudes, and the relationship they have with the resident.
- Carers found it difficult to adapt the way they care for residents approaching end-of-life, as the residents' routines change, and they begin to engage less.
- The struggle experienced by nurses to get anticipatory medication when residents have suddenly deteriorated after being discharged from palliative care.
- Time organising meetings, liaising with multi-disciplinary team and engaging the family in the end-of-life care for residents with dementia.

What I would have done differently is that I may have chosen to join the next intake of the Pioneer Programme as I was new in post when the programme started and as the clinical lead, I had many projects to oversee at the same time. Moreover, I may have considered using the Planning Ahead tool to help start the end-of-life conversations.

The programme has been a source of inspiration, motivation and learning. I have met amazing people and enhanced my leadership skills. The programme was cleverly designed to provide a space for the group to support each other through exchanging experiences. We were also able to implement the My Home Life leadership framework to promote best practice and positive relationship in our work places.

Health Innovation Network South London

My home life England

Increasing Supervision in the Care Home by Nurses

South London Care Home Pioneer Programme

Suhasini Raja; Brinsworth House, Richmond-upon-Thames, London, UK

Aim

To enhance care through introducing supervision for Health Care Assistants (HCA) in a care home setting by nurses.

Background

I am a Clinical Lead Nurse at Brinsworth House since 2013 and come from a family of nurses.

Brinsworth House is a nursing and residential care home situated in Twickenham. It is predominantly a home for retired entertainment artists of all genres – actors, singers, dancers, comedians etc. Twickenham is famously known as being the home of England's Rugby Team and the team's national stadium.

I chose to enrol on the Pioneer Programme after being encouraged by my manager, who'd suggested the course would help me develop in my career.

Introduction

Brinsworth House is staff by registered nurses and health care assistants. It was made clear through staff members opinions and CQC feedback, that health care assistants would benefit from receiving supervision to share their experiences, ideas, and concerns with the nurses. Supervision is carried out by the Matron and myself.

The project intended to implement quarterly supervision for HCAs, which would be facilitated by registered nurses. This project will help to provide a governance structure for all HCAs to ensure they are able to be heard and to help to improve the standards of different practices and procedures they deliver. This will in turn will enable a culture of openness, compassion, and continuous quality improvement at Brinsworth.

The project aimed to train registered nurses to facilitate supervision for health care assistants quarterly to acquire staff, service, and patient care feedback.

Method

Prior to the project, supervision was only being provided by the Matron and myself. Nurses were allocated staff who they'd supervise every quarter. A supervision matrix was utilised to track which staff members required supervision in a group setting on a quarterly basis. The registered nurses fed back any relevant information into their supervision which was facilitated by the clinical lead. The policy on supervision, information on what and how to conduct a supervision, and the benefits of supervision were shared with all staff involved.

The clinical lead also fed back to Brinsworth manager to discuss any issues or concerns raised, and any changes that had been suggested, for example, furniture arrangements or implementing a new activity. The data to establish a baseline was collected by looking back on activity from January 2022 onwards, during the project which was implemented in July 2022, when the registered nurses began conducting their supervisions, and for the duration of the project until October 2022.

Results

All the nurses reported feeling confident to hold group supervision sessions with their colleagues and to facilitate conversations that could prove difficult to manage. The health care assistants were happy that they were being heard by the nurses as they could see that suggestions given by them were being taken seriously. Any changes were acted upon which gave them a sense of involvement and feeling valued. To enable the supervisions to take place, the clinical lead ensured that extra staff members were allocated to relieve the registered nurses for the supervision.

The change was easy to monitor as prior to the project, no supervisions were taking place for health care assistants by nurses compared with regular supervisions after the project was implemented. There was a particularly strong response when the supervisions were first initiated and although that dropped off during the summer holidays, it did increase again the month after.

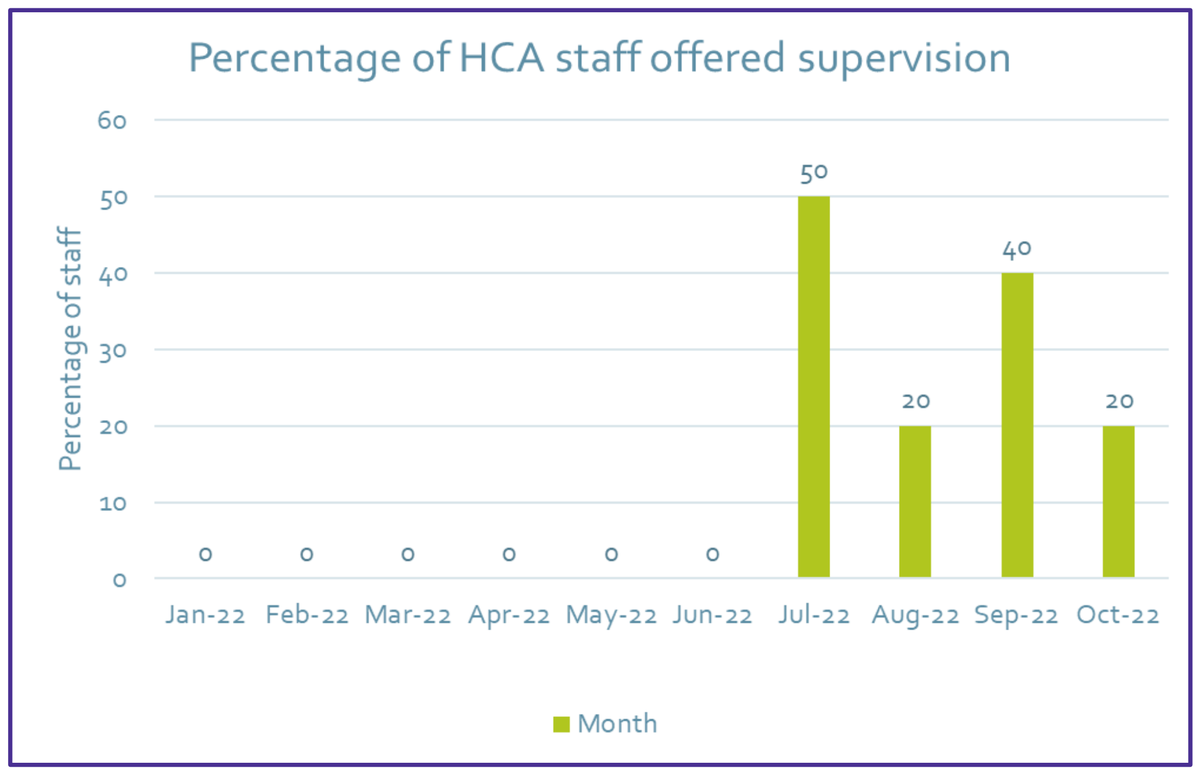
Conclusion

Brinsworth Care Home have successfully introduced group supervision for health care assistants by nurses to report on the work they have been engaging in with residents, the challenges they face and their recommendations for service improvements. Some of the successes have been improving the quality and thoughtfulness of care being provided from the home as it acts on feedback, increased morale and wellbeing of staff, and assurance that challenges and incidents are more likely to be reported.

Some of the challenges included finding the time for staff to come together to facilitate supervision, managing to supervise staff during school holidays, and finding staff to cover duties when supervision takes place.

The project has been able to ensure that all staff are receiving supervision as planned. The project therefore plans to continue until March 2023. After this financial year, the frequency of supervisions will increase to every two months.

I feel the Pioneer Programme has made me a more effective leader who is able to see the strengths staff members possess and delegate key roles as and where necessary.



The above graph indicates the percentage of health care assistants supervised each month from January 2022 – October 2022. There has been an increase in the number of staff supervised in the second half of the year.

Health Innovation Network South London

My home life England

The Royal Variety Charity