Summary of QNI Community Nurse-led Innovation Projects focused on improving health and well-being outcomes for people with frailty

(March 2019 to July 2020)

Contents

The projects reached 933 clients and 105 carers over the year, but the outcomes of the projects impact more widely as many of them have been adopted by the project lead's service provider and commissioners.

Introduction

The QNI is grateful to The Burdett Trust for Nursing for the generous funding that allowed these ten projects to fulfil their outcomes.

This is a summary report of the eleven QNI nurse-led innovation projects and programme that ran from March 2019 to July 2020. Ten projects successfully completed the project year; one project was unable to complete due to a change in the project lead role and employer.

- Tai Chi for increased wellbeing
- Darwen Healthcare Frailsafe project
- Improved nutrition and hydration in a residential care home
- Royal Voluntary Service health and wellbeing community hub
- Primary Care Frailty Project
- Frailty pathway for people with a learning disability (unable to complete)
- Identifying frailty in former carers of patients who have entered permanent nursing care from the Robinson Hospital in the Causeway locality of NHSCT
- Reaching out to the hard to reach
- Nurse-led case management of patients with frailty and multimorbidity (Frailty case management)
- Wound and pressure ulcer prevention and management using digital imaging in practice
- Stockport COPD advice on reviewing care in patients with frailty (SCARF)

Involvement

35 project staff and a further 104 healthcare and allied professionals were involved in the delivery of the work. The projects reached 933 clients and 105 carers over the year, but the outcomes of the projects impact more widely as many of them have been adopted by the project lead's service provider and commissioners and have become part of the service offer in a sustainable way.

Aims and objectives

At the beginning of the project year, each project team agreed an overall aim, specific aims and objectives for their project. A monitoring framework was then developed in order to agree on project outcomes and how the predicted outcomes would be monitored, measured and reported.

At the end of the project year the project leads were asked to report on their achievement in relation to each of their specific aims on a scale of 1 to 5.
(5 = fully; 4 = mostly achieved 3 = moderately achieved; 2 = partly achieved; 1 = not at all)
The QNI is delighted to report that 75% of project aims were fully or mostly achieved and 25% were moderately or partly achieved.

Reporting and monitoring

As part of the award agreement each project team submitted an interim report four months into the project which enabled us to evaluate the progress of the project. An end of year report is also required and a case profile which tells the story of one patient's journey through the life of the project. All eleven interim reports were submitted by the due date. The final report date was extended due to the Covid-19 pandemic from May 2020 to July 2020. Ten final reports were submitted by July 31st 2020 which provided clear evidence of progress and achievement.

Site visits

All projects except one (due to pandemic lockdown restrictions) were visited by the QNI Director of Nursing Programmes. The purpose of the site visit is to review the progress of the project against the project plan and offer appropriate support and guidance to the project team.

The site visits are very well received by both the project leads and the managers of the clinical areas. They provide an opportunity for the QNI to contextualise the project, to become familiar with the environment within which the projects are being led and managed and to engage with colleagues and managers supporting the projects. This level of attention to detail and support is evaluated well by all the project leads and the managers. The visits also provide an opportunity to engage with an organisation's communications team to publicise the project locally within their organisation and community.

QNI support and professional development programme

A real strength of project support are the workshops provided by the QNI. Project teams attended three two-day face to face workshops during the project year; the programme was tailored to support the teams through the delivery of the project. Topics included evaluating outcomes, writing for publication, creating a poster presentation, understanding commissioning, business planning, economic sustainability and creative thinking.

The project leaders also greatly appreciated the presence of Shirley Baines, Chief Executive at Burdett at several of the workshops and her interest in their work. This demonstrates to the project leaders the importance of the relationship between the Burdett Trust and the QNI and the importance given to following up the outcomes of funded projects and their impact on individual people, their families and carers.

The project leaders also report on their personal and professional growth in leading and managing a project and their increasing confidence in presenting their project outcomes to their peers, colleagues and key staff in their organisations', which occurs over the year of the project. Many go on to use the skills they have developed in project leadership to undertake further innovations in practice. All report that the leadership and project management skills they have developed have provided them with the confidence to develop further practice innovations for people, their families and carers.

This is clear evidence of the sustainability of the project outcomes, both in relation to the project outcomes themselves reaching a wider audience, with project leaders gaining the confidence to speak at conferences for example, and the impact of individual leadership skills, with project leaders inspiring others to focus on and to adopt a positive approach to innovation in practice.

Challenges

- Time pressures
- Managing change
- Data collection
- Organisational change
- Steep learning curve
- Lack of planning
- Assuming everyone is as committed as you
- Lack of administration support
- Pressure of other work commitments
- Unexpected sick leave

Promotion and dissemination

The QNI recognizes the importance of promoting the outcomes of these projects and providing a way of disseminating the findings to a wider audience to maximize their impact.

To that end, we are currently developing a new project section of our website which will showcase the projects, the outcomes and the resources developed. We are also able to link the project leads to Professor Alison While, a QNI Fellow and Consultant Editor of the British Journal of Community Nursing (BJCN), to encourage publication of their project outcomes in that journal.

All the projects will be featured and all resources which have been developed through the life of the projects will be added so that they are available to all visiting the website. The projects will be named as being funded by Burdett Trust for Nursing which will provide wider publicity to the Trust for the work that it does to support the development of healthcare.

Two projects were selected to present their work and outcomes at the annual QNI conference (online) in late October.

‘Ella said that she feels like she has more energy and that she is starting to feel like a person again and it makes her feel better.’

Individual project information

1. Tai Chi for Increased Wellbeing

Outline: This project set out to improve the well-being of people living with frailty in a care home, by attending weekly Tai Chi classes over 10 months, in order to reduce falls and improve balance.

The participants were assessed for falls risk and balance by having timed get up and go (TGUG), timed unsupported stand (TUSS), and functional reach tests before starting the classes, then again at 5 months and 10 months. Their well-being was measured using the Warwick-Edinburgh Mental Wellbeing Scale.

Comment: Ella (pseudonym) had started to feel that her whole independence was being taken away and people were forgetting who the real Ella was. She enjoyed social interaction, but felt that the activities that were on offer at the care home were quite childlike and did not consider that they were still adults. Following a fall that resulted in a fractured hip, Ella felt very low in mood and not as sociable. She was even more dependent on others and this really impacted on her mental and physical well-being.

Ella attended most classes with the support of the activity coordinators and the rest of the group. There were times that her mood dipped and she felt that she couldn’t face the Tai Chi class. However, through encouragement from the group she would come down, join in and enjoy it. Ella said that she was starting to feel part of a small community and began to look forward to the weekly classes. She enjoyed being part of the group and has made new friendships with people. She feels very protective of the group and there is a bond amongst them. Ella says she has a sense of worth and has been made the lead voice for the group to help the Tai Chi classes continue after the funding has ended which has now been agreed.

Ella said that she feels like she has more energy and that she is starting to feel like a person again and it makes her feel better. Ella was recently re assessed using the Rockwood frailty score and is now considered moderately frail instead of severely frail.

‘The best part for me as the project lead has been seeing her interacting and happier. During one conversation she said something to me that I did not understand, so I asked her what she had said. She laughed at me and said that she had spoken in Swahili and said, “You won’t understand this”!! Her sense of humour has certainly returned’.

Some quotes from the participants were *‘life is good; it has given me a better outlook; it has made me more active; it has helped me relax; it makes me feel better’ .*

Key outcomes: The primary outcome was to have an improvement in overall wellbeing and improved wellbeing scores at the end of the project using the Warwick-Edinburgh Mental Wellbeing Scale. The secondary outcome was to improve balance and reduce falls risk. For dynamic balance the mean Timed Get up and Go (TGUG) was measured - how many seconds it takes for the participant to stand and walk 3 meters, turn and sit back down.

For functional balance the mean Timed Unsupported Stand (TUSS) was measured. The person stands unsupported for as long as they can for up to 60 seconds. The timing stops when they place their hand on the table or until they have stood steadily for 60 seconds. In addition, the functional reach test was used, which is a simple test of balance that can be used to identify people who may be at risk for falling while reaching. All of these scores improved throughout the time of the project.

Future: Both care homes involved in the project are continuing to fund tai chi classes, although not weekly due to financial constraints. Other care homes in the local area are also having Tai Chi classes for their residents.

‘Access to healthcare has definitely improved as some of those patients may never have accessed any services at all. We get regular family and friends feedback thanking the practice for our input.’

2. Darwen Healthcare Frailsafe project

Outline: This project involved a robust frailty review of patients scoring high on the electronic frailty index and to screen admissions and out of hours calls that relate to conditions that may be associated with frailty.

This would improve the health and wellbeing of patients living with frailty in the practice, reduce avoidable admissions to hospital, provide proactive reviews to effectively care plan and improve communication with secondary care colleagues.

Daily slots were assigned for the paramedic practitioner to look at discharge letters, out of hours calls and action and identify any needs. Weekly slots were added for multiple team members to undertake in depth frailty reviews for those on the frailty register. A quarterly multidisciplinary team meeting was held weekly to discuss any admissions of patients who have severe frailty and regular meetings were held with the transformation manager for frailty and end of life care to try and find ways to improve communication with secondary care.

Comment: *‘Access to healthcare has definitely improved as some of those patients may never have accessed any services at all. Now that we seek to proactively assess and review people, rather than provide reactive care we have enabled those who don’t engage to have a full meaningful review and offer any services we feel may benefit them such as Age UK, wellbeing service, community nursing services or the practice. Many have found it beneficial and have commented on how we have helped them. We get regular family and friends feedback thanking the practice for our input’.*

Key outcomes: The outstanding work that the practice has completed so far as a team around caring for people with frailty.

Any patient over 65 has the electronic frailty index score calculated and the proactive frailty review is completed along with the Rockwood score.

The patient is then referred into any services available and deemed necessary and a care plan is generated.

Any new member of staff is taught how to conduct a meaningful frailty review, with a pack containing available services to refer into plus available support should they need it.

Future: The frailty assessments and linked work have now become embedded into practice and the whole practice team remain involved to continue this work.

3. Improved Nutrition and Hydration in a Residential Care Home

Outline: This project aimed to improve the health of residents in a care home. The residents have dementia and other long term conditions and are at risk of malnutrition. This increases their risk of falls, delirium and hospital admission.

The aim was to reduce malnutrition by using social prescribing methods enabling the residents to enjoy a healthier, happier life. The project aimed to encourage a dementia friendly approach to food and hydration.

Comment: Nutritional Buddies in the care home were selected and trained. The CQC inspection in February 2017 rated the care home as 'requires improvement'. The last visit in December 2019 rated it as "good". They specifically mentioned the Nutritional Buddy Programme implemented as part of the project – *'Some staff had been involved in a 'nutrition buddies' training programme, which helped to raise their understanding and awareness about the support people needed. We observed a number of positive interactions across the inspection of people being supported and encouraged at mealtimes, with other choices being offered if people said they were not hungry'.*

A new decorated drinks trolley round was introduced at 11.00 and a bell is rung to alert the residents to drink time. This is in addition to their tea trolley round. A new hydration station is available at all times in the entrance area with chairs and plants. They also now have home-made shakes rather than expensive prescription supplements. There is a new practice pharmacist who helps to reduce the amount of prescription supplements.

The CQC also mentioned this in their report – *'A hydration station had been introduced since the previous inspection and was based in the reception area. Hot and cold drinks were available and we saw it was a central hub of activity throughout the day, with staff supporting people and people chatting with each other'.*

Additionally, residents are more active - gardening as one example. The residents play a board game advising them of the importance of keeping hydrated. If they win they are rewarded with daffodil bulbs to plant.

Key outcomes: The CQC recognised the project work in their report; seeing the residents become more active – gardening, playing the hydration game, clapping their hands when the drinks trolley arrives; no longer prescribing unnecessary nutritional supplements and making financial savings; the care home tweeted their new hydration station; the practice recognised the project achievements by rewarding the two project leads with employees of the month; there is an interest from the CCG to use the training package on nutrition and hydration for residential care homes in the borough.

Future: The culture of the nutritional buddy will continue and the care workers will train others. The care home manager will take the idea of a nutrition buddy to other care homes that are part of the same organisation. The CCG is interested in taking the project ideas to other care homes in the borough. No further funding has been offered at this stage however a lot of interest has been generated. The CCG is now funding the practice to provide the enhanced GP/ANP visits to the care home whereas it was not before.

‘The patients speak very highly of the Hub, many calling it their ‘life line’. We have many amazing stories captured of the positive impact the Hub has had on people’s lives.’

4. Royal Voluntary Service Health and Wellbeing Community Hub

Outline: This project aimed to help combat loneliness and isolation with the frailest and most vulnerable people within the community and to provide a stimulating and safe environment where they can attend weekly to gain friendship, company, along with health promotion, advice and treatment from health care professionals to keep them safe and well at home. This would ultimately prevent the misery of loneliness which exacerbates physical illness.

Comment: *‘A Community Matron’s role has become over the years, crisis managing and preventing hospital admissions. Gone are the days of monitoring and pop in visits to check there are no changes to symptoms. The way we are working within the Hub, means the volunteers have become the eyes and ears for us. This means signs and symptoms have been acted upon in a timely manner, preventing more physical illness, exacerbations and potential hospital admissions. Therefore the impact the Hub generally has on the most frail and vulnerable people has greatly improved access to health care when it is needed. The members have had someone they can call on, a connection to others within their community, a befriender and a time each week where they have access to a health care professional who can reassure, treat, or test for their problem. This is why we would like to expand the Hub to other communities so we have a wider impact.’*

‘The patients speak very highly of the Hub, many calling it their ‘life line’. We have many amazing stories captured of the positive impact the Hub has had on people’s lives. The volunteers also have a huge amount of satisfaction from caring and looking out for the members’.

‘A lovely friendly place to go! My Happy place.’

‘I’ve met new friends it has taken me out of myself and I feel safe. I love it’.

‘Gave me a new purpose and interest I enjoy the talks and interaction with new friends.’

Key outcomes: The Hub has provided an enjoyable and safe environment for people with complex health problems and frailty to meet on a regular basis, where nursing staff can review these people, some of whom are very vulnerable. Several potential hospital admission and GP clinic appointments have been prevented. Stories and examples have been collected of how the Hub volunteers and community matrons attending have worked together in recognising and acting on vital signs and symptoms of the members. There have also been social benefits from people connecting within their community, making new friends, interacting with children from the school and nursery, learning new skills such as water colour painting, as well as gaining vital information about their health and aids and gadgets that would help them at home.

Now with the covid pandemic, the Hub has adapted and remains a life line to its members. The garden visits have proved over and over their worth by having someone familiar to them ask how they are coping. Many GP contacts have been avoided and hospital admissions potentially saved.

Future: The Hub is financially comfortable. There is money for more equipment to develop the clinic space and attract more health care professionals and provide a comfortable environment for people. Plans are in progress for a second Hub to open in a different area, to reach new communities.

The Hub is not currently open due to the Covid-19 pandemic, however it has been adapted to make garden visits to some of the more vulnerable members of the community.

‘At the end of the assessment I could see a different Olive. She was keen to change things and with help and support she was willing to make changes to improve her quality of life.’

5. Primary Care Frailty project

Outline: The project aimed to develop a robust system that supports the identification, assessment and management for people identified as severely frail within 3 GP practices and move from a reactive disease driven model to a healthy ageing model, achieve a reduction in unnecessary admissions to hospital and reduce unnecessary GP appointments. This would also invest and prepare the primary care nursing workforce and associated allied health professionals to meet the demands of an ageing population.

Comment: *‘Initially at the start of the assessment Olive was quite withdrawn but as the conversation progressed and as communication methods were put into place she began to chat more and answer the questions for herself. She was pleased with this as she was able to put her views and what she would like moving forward and being involved in her plans.*

During the assessment I could see that Olive was able to interact and did have capacity to make decisions for herself, her daughter was also surprised as to how much she opened up and talked about things.

At the end of the assessment I could see a different Olive to the one who had entered my room at the start, she was keen to change things and with help and support she was willing to make changes to improve her quality of life. Her daughter’s mood improved by the fact that we could assist her in making her mum’s and the family’s life a more positive day to day experience rather than the negative times they had endured in the past.

During the assessment we discussed Olive’s ‘End of Life’ wishes which had not been discussed before. This started off with me asking questions and Olive answering but after a little while and further questioning and suggestions Olive’s daughter got involved and they began to discuss openly different possibilities and wishes. This area had never been explored before and Olive’s daughter quoted ‘it was like giving her a key to the door to talk to her Mum about it’.

Key outcomes: Reduction in repeated hospital admissions: reduction in GP appointments; patient satisfaction with the assessment and outcomes; patient carer’s and next of kin articulated that the assessment gave permission for difficult conversations to be built upon regarding advanced care planning.

Future: The assessment and management of those identified via the electronic frailty index will be undertaken by GPNs and newly funded healthy ageing coordinators. In addition, it is anticipated that QoF will have elements of frailty assessment.

6. Identifying Frailty in Former Carers of Patients who have Entered Permanent Nursing Care from the Robinson Hospital in the Causeway Locality of NHSCT

Outline: To identify frailty in former carers using the Rockwood Clinical Frailty tool when a relative/loved one has been admitted to permanent nursing care.

This project offers the possibility of shared responsibility to provide support for frailty, with the opportunistic screening of former care givers in a proactive and timely manner. From early identification, to intervention, to prevention and education to care, with support and rehabilitation by considering a more widely encompassing model, working closely with the Community Hospital staff, district nursing teams, nursing home registrants, nurse specialists and members of the multidisciplinary team, voluntary and statutory agencies.

Comment: *'This project benefited me so much as I was listened to as a carer and felt valued in the professionals asking me questions and I felt I was able to add to discussions on the role of carer and frailty. Before this project, no one has really ever listened to me as a carer nor took the time to ask what would make a difference to me and what would help me not get frail in the future. It was all so positive'.*

'The choice of membership was very innovative as every discipline within the Community Hospital was represented, not just pharmacists, nurses, doctors, physiotherapists, dieticians and occupational therapists, but also those upon whom the daily working of the Hospital depended e.g. secretarial staff, cleaners and myself included as a Carer representative They were all made to feel valued and I was always invited to give the opinion as a carer. The difference this has made to me as a carer, being listened to and also to consider my own needs, was something as a carer I had not done before'.

'Sometimes one feels alone and unsupported; not so when one can see the enthusiasm and perception that has emerged from this unique carer project, led by someone with such passion and insight. I do hope that the Project can be continued and developed - it has been the most valuable project I have ever witnessed develop over my own fifty years of Medical Practice'.

Key outcomes: Frailty screening of 10 former carers within the Trust of residents going into permanent care from the community hospital; increased knowledge of the condition of frailty; signposted to access community and voluntary services.

The key outstanding achievement was the involvement of carers being screened for frailty as a new innovation. Until this project commenced, no carer of a relative/loved one had their frailty assessed pre-nursing home admission in the organisation.

Future: Early discussions about expanding the work into 18 care homes in another locality are ongoing with senior management and local GPs to try to expand the work and continue to screen carers for residents going into permanent care to reduce frailty in this population.

‘The benefits of the project have been that everyone is more competent at care planning and has a more holistic approach when visiting this population.’

7. Reaching Out to the Hard to Reach

Outline: This project aimed to improve and make more equitable the service offered from the General Practice and to review and improve the provision of long term condition monitoring for people who are housebound.

Comment: The individuals involved as part of this project like the visits and feel better looked after. Access to healthcare has improved and most housebound patients received two visits.

They had greater contact with the surgery and the opportunity to establish relationships

They had routine long term condition monitoring for chronic obstructive pulmonary disease, diabetes, hypertension, mental health and cardio vascular disease. The project lead commented *‘I found and still find the visits a really enjoyable part of my working day’.*

Key outcomes: The key outcomes were a reduction in the unplanned admission rates for people who are housebound, in particular those with chronic obstructive pulmonary disease; an increase in the achievement of the 9 key care processes for people who are housebound with diabetes; to record an improved Patient Activation Measure (PAM) score for people who are housebound.

The benefits of the project have been that everyone is more competent at care planning and has a more holistic approach when visiting this population, asking about their conditions, their social circumstances assessing frailty falls risk and reviewing medicines

Future: The practice will continue with the new home visiting programme for people who are housebound with complex needs.

‘One of the patients found it so beneficial that she told a number of other residents within her sheltered accommodation complex about the project. They have since been referred and are now on the caseload.’

8. Nurse-led Case Management of Patients with Frailty and Multimorbidity (Frailty Case Management)

Outline: The project aimed to quantify the cost effectiveness of targeted nurse led management to provide evidence that working differently can help manage the growing demand on a GP’s time, reduce hospital admissions, decrease prescribing and social care costs and improve patient experience.

Feedback from GP colleagues say they are insufficiently resourced to provide the more long-term, intensive proactive care management that most patients with complex needs require.

GPs initially identified patients for referral. These patients are ones that are historically hard to manage due to complex long term conditions, or are patients that are seen as high service / high GP users or as having frequent hospital admissions.

Comment: There was an underestimate of the impact that the project had, not just for the patients but for their families. A patient’s wife reported she was *‘eternally grateful for our support’.* Initially the majority of time was spent focused on the patient, but it soon became apparent the impact for carers and family members was significant.

Patients now have a single point of contact for needs and are encouraged to make contact between visits and reviews if needed. One of the patients found it so beneficial that she told a number of other residents within her sheltered accommodation complex about the project. They have since been referred and are now on the caseload.

Key outcomes: To identify the root causes of the most complex factors underpinning each patient’s frailty; proactively implement evidence based interventions and monitor their effectiveness by regular reviews; demonstrate the impact including patient satisfaction and cost effectiveness of the interventions in order to create a case for this project to be rolled out further.

Patients seen by the project team report a better quality of life and wellbeing outcomes, measured with a patient confidence scale and feedback survey, which showed a decrease in their anxiety and depression scores; reduction of hospital admissions, reduction in GP contacts and improved clinical outcome measures for patients – showing an increase in symptom management.

GP feedback has indicated that it has reduced their workload, and in some cases has reduced time spent on particular patient groups by up to 50%. The project has also improved communication within the surgery and improved access for patients to other services.

Future: A caseload of approximately 34 patients is still being held, with a multitude of long term conditions, which are reviewed regularly. The GP surgery used for the project feel it would be beneficial to expand the project so that the current caseload could be increased.

The project was temporarily suspended due to the covid pandemic. However, this has enabled time to focus on the next steps.

Following the success of the project, case management is now included as part of the ongoing management of patients with frailty. This has been agreed at both a local level and within the local Clinical Commissioning Group. This is an excellent result and shows the real impact the project has made to both patient care and at a workforce level. This can now be built upon to include a much larger cohort of patients with increased numbers of staff.

9. Wound and Pressure Ulcer Prevention and Management using Digital imaging in Practice

Outline: The introduction of digital wound imaging with a 3D digital camera enabling wound size and depth to be measured, together with the ability to map and monitor progress over time.

Comment: Access to this type of digital health care has improved outcomes for people who have a wound and patients have expressed positivity in being able to immediately see the improvements that they were making or where they may have been deterioration, to enable a discussion to take place with a rationale for changes to treatment plans.

This is the first time that a digital technology project has been introduced into clinical practice. Working with a team who have been able to explain and decode has been crucial to its success. What has made this work well is the team wanting to succeed and championing the project.

Key outcomes: Patients liked to be able to see their wound in pictures and see the progress they were making; staff liked using the camera once they had mastered its use, although in the patient's home it was a little cumbersome as it needed to connect to a laptop via a cable. Once the camera was moved to the alternative Leg Ulcer clinic, the staff mastered the camera quickly and found it good to use in its ability to digitally measure the wound, removing some of the variations for manual measurement.

Nurses have engaged in the process and have developed in their understanding of how to bring a piece of clinical equipment/innovation into practice which is much more useful than they ever expected.

Future: The project will continue and will now include the testing of the Silhouette Plus camera that can be used on any iPhone. This is potentially a better option for community practitioners providing care in the home.

Staff now report better knowledge of using inhaled therapies and managing other aspects of COPD.

10. Stockport COPD Advice on Reviewing Care in Patients with Frailty (SCARF)

Outline: Improve management and health outcomes by filling the gap in provision of care for people with frailty and chronic obstructive pulmonary disease (COPD) who reside in a residential/nursing /care home setting and to improve their management pathway through improving the education for the carers.

The project aimed to identify a predefined number of residents who fit the criteria. With help from the pharmacy team of the local CCG who work at the GP practices, a large practice was selected that was likely to provide the numbers of residents required for the project. The pharmacy team would then build and run a search for these residents on the practice clinical system. They would provide a list of residents who would be visited. Each resident would then undergo a full COPD assessment and review with the specialist COPD nurse. A medication review would be carried out by the clinical pharmacist where special attention would be given to reduce polypharmacy. A detailed summary would be written for the GP to review for each resident containing the results of the clinical assessments.

Comment: Residents who reside in care homes are now able to access the specialist COPD Team. After the education and training sessions, care staff from care homes that didn't host the project contacted the specialist COPD for inhaler reviews for some of their residents and also with queries about medication. This avenue remains open and contact details for the specialist COPD service will be distributed as part of the information in the folders for the care homes which were produced as part of the project.

Staff now report better knowledge of using inhaled therapies and managing other aspects of COPD.

Key outcomes: The work with one GP practice and five care homes provided better continuity and efficiency instead of working with several GP practices. COPD assessments were carried out with 20 residents along with holistic medication reviews. There was improved awareness of the Frailty Index score by GPs and improved frailty scores with some residents. There was improved education and knowledge for 20 carers who attended the education and training events. They are now more aware of the impact and importance of the management of residents with COPD as regards inhaler technique, use of inhalers prior to exertion/exercise, regular use of inhalers for residents with cognitive impairment, symptom management with fan therapy, smoking cessation, the benefits of exercise and increased physical activity for all residents, the importance of a varied healthy diet for all residents and the benefits of good hydration. Personal smoking cessation advice was given to 3 residents. An information folder on COPD management exercise, pulmonary rehabilitation, diet and nutrition, medication, inhaler use and other useful resources was produced for each care setting. The folders are to be distributed to the 50 care homes in the borough after the current Covid pandemic has subsided.

For the 20 residents who were involved in this project there has been an improved quality of life and possible reduction in the risk of hospital admission through the interventions provided. This has the potential to have a similar impact on many more care home residents by educating care staff about COPD, frailty and the other factors which can affect health and wellbeing outcomes for other residents; these include fan therapy for anxiety, good nutrition, constipation, exercise and hydration.

Excellent feedback was received following the education and training events.

Future: The plan was to present the project to the CCG commissioners to seek further funding to continue the project in other care homes but with the Covid pandemic it has been necessary to put these plans on hold for now.

The Queen's Nursing Institute
1A Henrietta Place
London W1G 0LZ

020 7549 1400
mail@qni.org.uk
www.qni.org.uk

Founded 1887
Patron HM The Queen