Unplanned hospitalisations of the nursing home residents are frequent, often repeated and variable according to the countries.

- Some hospital admissions and emergency department visits could be avoided if comorbidities and geriatric syndromes were managed optimally or prevented in the nursing home. These are potentially avoidable hospitalisations (with a frequency of 19% to 67% according to the study).
- Other hospitalisations may be considered inappropriate hospitalisations. In this case, the relevance and/or risk-benefit ratio is/are debatable when compared to care which could be provided in the nursing home or by other organisations without hospitalisation, and which does not reduce the resident’s chance of survival.

These potentially avoidable or inappropriate hospitalisations of the nursing home residents have a negative impact on these frail or dependent elderly patients, causing functional and cognitive decline. The prevention of these hospitalisations requires several complementary approaches. Firstly, chronic diseases and geriatric syndromes can be managed optimally by the general practitioner, and secondly, risk prevention policies and alternatives to hospitalisation must be implemented by the nursing home. This document discusses how to reduce potentially avoidable or inappropriate unplanned hospitalisations of nursing home residents, by targeting the most frequent causes and focusing on the interventions which have proven efficacy in the literature.

How to reduce unplanned hospitalisations of the nursing home residents

Key Points

SET UP THE BASIC CONDITIONS
- Guarantee 24/7 access to care
- Ensure the coordination and continuity of care in the nursing home with the medical team and the general practitioners
- Organise multidisciplinary working
- Fill in resident transfer forms (DLU) and set up a managing emergencies procedure

MAKE A STATUS REPORT AND PRIORITISE
- First, make a status report on the hospitalisations of the nursing home residents (planned and unplanned) and risk factors for hospitalisation
- Assess the internal and external resources available
- Prioritise the interventions to implement

USE INTERNAL AND EXTERNAL RESOURCES
- Inform and train the caregivers team
- Inform and engage general practitioners and other private professionals and hold regular geriatric care coordination committee meetings
- Inform residents and their families
- Develop effective partnerships and draw up agreements with external resources

TAKE ACTION, MONITOR IT, ADAPT AND CONTINUE
- Start with one or two realistic and realisable objectives
- Follow the feedback and the various indicators in multidisciplinary meetings; adapt and formalise interventions and continue them over the long term
- Inform and motivate the caregivers team
- Build on successes to continue with other objectives
What needs to be done

Essential prerequisite: set up a continuous quality improvement initiative.

- Guarantee 24/7 access to care (MEDEC1, Manager).
- Involve general practitioners and other private professionals (MEDEC).
- Organise within the nursing home:
  - effective coordination among healthcare teams in the nursing home and between general practitioners and other private professionals (MEDEC, IDEC);
  - caregivers teams planning to optimise continuity of care (Manager, IDEC);
  - multidisciplinary work by caregivers team (MEDEC, IDEC)
- Communicate objectives and interventions:
  - inform and engage caregivers team (Manager, MEDEC, IDEC);
  - inform and engage general practitioners and other private professionals (MEDEC, geriatric care coordination committee) (Focus 5);
  - inform residents and families (Manager, MEDEC, IDEC, Social Life Committee).
- Define realistic and realisable objectives and follow them:
  - write a status report on hospital admissions and related risk factors, in particular: palliative care, cognitive impairment, lung disease, falls, medicines (including psychotrophic drugs and AVKs3), vitamin D deficiency, flu vaccination and pneumococcal vaccination (MEDEC);
  - prioritise the interventions to implement (MEDEC, Manager and IDEC);
  - make note of the expectations of residents and their families;
  - assess internal resources as regards the objectives and train caregivers team (MEDEC, IDEC);
  - assess external resources that can be used to meet objectives and develop partnerships (MEDEC, Manager);
  - choose one or two realisable objectives and follow-up indicators for these (MEDEC, IDEC and Manager);
  - monitor the results in multidisciplinary meetings, adapt interventions in line with feedback, formalise interventions and continue them over the long term;
  - build upon successes to continue with other objectives.

Interventions to improve the quality of care in nursing homes

1. Improve management of emergencies:

   This is a priority intervention and determines the success of other interventions.
   Build relationships of trust and formalise links with the local hospital and its emergency department s: (MEDEC, Manager).

2. Increase flu vaccinations among nursing home residents and caregivers:

   - organise campaigns in the nursing home to promote flu vaccination among residents, caregivers, and visitors; families, volunteers and private healthcare professionals4;
   - organise flu vaccination sessions for caregivers which could be carried out by the nurses (except the primary vaccination)5;
   - at the same time, promote pneumococcal vaccination for nursing home residents.

3. Reduce hospitalisations for pneumonia

   - Prevent pneumonia among residents:
     - promote flu vaccination and pneumococcal vaccination for residents;
     - promote flu vaccination for caregivers;
     - ensure residents have good mouth hygiene with regular teeth brushing;
     - promote hygiene measures: standard precautions and additional “droplet” precautions in the case of transmissible infectious agents6;
     - prevent aspiration pneumonia: identify residents at risk and train caregivers in assisting with eating and what to do if the resident swallows the wrong way. If necessary, prescribe an examination by an occupational therapist.
   - Treat pneumonia in the nursing home:
     - draw up a multidisciplinary protocol for treating pneumonia in nursing homes, in collaboration with general practitioners (Focus 1)

4. Enhance palliative care and supportive care in nursing homes (Focus 3 and Focus 5B):

   - identify residents in palliative care;
   - open a dialogue about advance directives and nominating a trusted person;
   - encourage the organisation of multidisciplinary team meetings in the nursing home7;

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1 MEDEC: nursing home coordinating doctor.
2 IDEC: nurse coordinator.
3 AVKs: antivitamin K (oral anticoagulants).
4 DLU: Dossier de Liaison d’Urgence [resident transfer forms], 2015 version, HAS/ANESM [National Agency for Assessment and Quality in Medical and Social Care Establishments and Services].
5 Guide d’utilisation du DLU [DLU User Guide], 2015, HAS/ANESM.
6 DGAS/SD2 circular No. 2005/245 of 16 September 2005 (Directorate-General for Health, 2006 #137) relating to flu vaccination in medical social establishments.
8 July 2012 HCFP [High Council for Public Health] report: Conduite à tenir devant une ou plusieurs infections respiratoires aiguës dans les collectivités de personnes âgées.
9 The procedures for these multidisciplinary team meetings are set out in the 2005 Leonetti Law on patient rights and end-of-life care.
Interventions targeting the most frequent causes of unplanned hospitalisations in nursing homes

These interventions have proven efficacy on intermediate factors (falls or improving the appropriateness of prescriptions) but not on reducing the overall number of hospitalisations.

1. Reduce falls in nursing homes:
   ▶ Propose vitamin D supplementation to all residents (Focus 2).
   ▶ Multifactorial interventions to prevent falls (Focus 4): evaluate residents’ fall risk using a multifactorial assessment on admission to the nursing home, and then annually or as needed following a fall. Based on the results, offer the resident a personalised multifactorial intervention for preventing falls.
   ▶ Encourage physical activity among care home residents. This should be appropriate to the resident’s level of frailty and the risk factors for falls identified in their assessment:
     - physical activity as part of reeducation or rehabilitation, carried out on a one-to-one basis by a physiotherapist;
     - appropriate physical activity in small groups of similar patients, arranged within the nursing home, with a physiotherapist, occupational therapist, psychomotor therapist or STAPS 10, depending on the nursing home’s resources.

Physical activity helps to maintain residents’ independence and it should be maintained by supporting residents in their everyday activities, using caregivers.

2. Reduce adverse effects related to drugs in nursing homes:
   ▶ Set up a risk management policy on medicines. Implement a medicines risk reduction policy around four areas for improvement 11:
     - improve medicines use (list of preferred medicines, practice guidelines on psychotropic drugs, pain management protocol, monitoring practices involving the preparation of crushed medicines in nursing homes, consulting a geriatrician, etc.);
     - assess the resident’s medicines management cycle safe (include the medicines policy in the establishment’s plan, involve the geriatric care coordination committee, define the pharmacist’s role in the nursing home, encourage reporting and analysis of adverse effects related to drug);
     - encourage approaches that are alternative and complementary to psychotropic drugs 12;
     - optimise the nursing home’s information system (encourage computerisation and interoperability with IT tools used by the general practitioner and pharmacist; prescribing software, etc.).

Increase the care provided in the nursing home:

1. draw up a list of care services and care that can easily be provided in the home, so that transfers to emergency departments can be avoided;
2. make available the resources needed to provide this care: medical devices (catheters, suture kits, etc.) and partnership arrangements (X-rays within the care home, laboratory samples, etc.);
3. draw up protocols for providing these treatments and services and train caregivers in following these protocols;
4. make these treatments and services available to the right patient at the right time, optimising continuity of care provided by the nurses and ensuring 24/7 operation for medical triage of emergencies.

10 STAPS: professional trained in the science and technique of physical and sports activities
13 Prescription of medicines in the elderly (PMSA) programme, 2009, HAS.
15 Modalités d’arrêt des benzodiazépines et médicaments apparentés chez le patient âgé Sept. 2008, HAS.
17 Prise en charge des surdosages en antivitamines K, des situations à risque hémorragique et des accidents hémorragiques chez les patients traités par antivitamines K en ville et en milieu hospitalier [Management of antivitamin K overdoses, situations with a high risk of bleeding and haemorrhagic CVAs in patients taking antivitamin Ks in the community or in hospital], 2008, HAS.
18 Protocoles pluriprofessionnels des soins de premier recours. Exemple gestion quotidienne des AVK [Multidisciplinary protocols for primary care. Sample daily management of AVKs], 2011, HAS.


July 2015

THE ORIGINAL FRENCH VERSION IS THE LEGALLY BINDING TEXT
2. Increase healthcare resources in the nursing home

Beyond a minimum threshold, the impact of increasing healthcare staff hours on hospitalisations will depend on the home’s ability to deliver the right care at the right time to the right patient. Increasing hours of healthcare staff should therefore be considered in relation to objectives that have been set based on needs identified within the resident population. It should be accompanied by:

- optimising the healthcare staff roster to ensure the best continuity of care during the day, at weekends and at night;
- training healthcare staff to improve their skills: managing emergencies, palliative care and pain management, managing behavioural disorders, and care protocols for reducing hospitalisations (treatment of lung disease, etc.);
- increasing the nursing home’s care capacities.

Interventions to increase use of resources outside the nursing home

1. Increase geriatrics expertise:
   - Integrate the geriatric network:
     - geriatric medicine, geriatric psychiatry or old age psychiatry departments, day hospitals, memory centres, etc.
   - Involve geriatrician in the nursing home:
     - a multidisciplinary mobile geriatrics team (EMGE);
     - regular consultations or phone consultation with a geriatrician;
     - a telephone line between the hospital geriatrician, MEDEC and treating doctors involved in the nursing home;
     - geriatric healthcare networks.

2. Increase palliative care expertise:
   - Integrate the palliative care network:
     - palliative care units, palliative care beds in hospital departments;
     - geriatrics or medical departments with a mobile palliative care team (EMSP).
   - Involve palliative care specialists in the nursing home:
     - EMSP;
     - palliative care networks.

3. Increase the use of Hospital at Home (HAH):
   - Create a formal partnership between the nursing home and an HAH;
   - Increase the use of HAH in the nursing home. Through HAH, the patient can be provided with complex and/or technical hospital care in the care home, and is ensured care coordination with 24/7 access to nursing care.

4. Increase the use of telehealth in the nursing home:
   - increase the use of telehealth in the nursing home in partnership with specialist hospital services, SAMU Centre 15, an EMSP, etc.

Telehealth can be used to provide all nursing home residents with specialist care (geriatric, psychiatric, palliative care, etc.) or to ensure that emergencies are medically triaged, particularly in areas where healthcare resources are scarce.

What it is necessary to avoid

Do not hospitalise residents unless their health requires it. Do not take action without involving general practitioners and other private health professionals.

Follow-Up Indicators

Indicators and how they change over time should be interpreted in light of the care home’s resident profile and internal and external resources. They do not necessarily reflect a “failing in the provision of care”. They cannot be used to compare one care home with another, or to define good practice standards.

The proposed list of indicators is not exhaustive. Each care home should choose its own follow-up indicators based on its priorities, the objectives it has chosen and the interventions implemented.

Example indicators:
- number of unplanned hospitalisations via an emergency department per year
- total number of hospitalisations per year
- total consumption of neuroleptics in the nursing home per year
- total consumption of benzodiazepines and other sedative drugs in the nursing home per year
- incidence of transfers to the emergency department with resident transfer forms
- flu vaccination rate among residents
- flu vaccination rate among nursing home staff
- pneumococcal vaccination rate among residents
- falls rate per 1000 resident-days
- number of falls-related transfers to the emergency department or hospital admissions per year
- number of medicines-related iatrogenic incidents reported by the nursing home per year
- number of advance directives signed by residents in one year
- number of residents treated through HAH in the nursing home per year
- number of interventions by an EMGE in the nursing home per year
- number of interventions by an EMSP or palliative care network in the nursing home per year
- total number of deaths, number of deaths in the nursing home and number of deceased residents who had received palliative care in the nursing home per year.

Most of these indicators already feature in various documents, such as the medical activity report, the Anesm national survey on welfare in care homes and the continuous quality improvement initiative follow-up (internal assessment).
What you need to know

**Predictive factors of hospitalisation**
- Increased age.
- Increased levels of dependency.
- A hospital admission in the past 6 months.
- Having been recently admitted to a nursing home.
- No advance directives or palliative care programmes in the nursing home.
- Certain diseases: heart failure, respiratory problems, genitourinary conditions and infections.
- Physical restraint, pressure ulcers, enteral nutrition and the use of catheters or new drugs.

**The main reasons for unplanned hospitalisations of nursing home residents are:**
- Falls (1/3, with half involving fractures), cardiorespiratory decompensation (30%), and then urinary and gastrointestinal problems, neurovascular conditions and behavioural disorders.

**Medicines in nursing homes**
- 20% of hospital admissions in elderly people aged 80 years and over are related to a medicine.
- Four classes of medicines account for 80% of these hospital admissions: antihypertensives/diuretics, antidiabetic drugs, AVKs and psychotropic drugs.
- The main classes of medicines prescribed in nursing homes are psychotropic drugs: antidepressants (32%), anxiolytics (27%), hypnotics (22%) and neuroleptics (15%). Their therapeutic value is low.

**Palliative care in nursing homes in France**
- More than 90,000 residents die each year in a nursing home, i.e. an average of 20 deaths per year per nursing home. 59% of them were receiving palliative care. 23% of residents are hospitalised as an emergency at least once in the 2 weeks before their death. 25% of residents die in hospital. 8000 residents die each year within hours of their admission to an emergency department.

**Effective interventions found in the literature:**
- Interventions to improve the transfer of information (fill in resident transfer forms) and the management of transfers to emergency departments
- Flu vaccination of care home residents
- Multidisciplinary protocols for treating pneumonia in nursing homes
- Interventions to identify residents who receive palliative care and to increase palliative care in nursing homes
- Advance care planning for residents with severe cognitive impairment
- Strengthening the home’s care capacities
- Strengthening geriatrics expertise in care homes (mobile teams and geriatrics consultations)
- Telehealth in care homes
Focus 1. Developing a multidisciplinary protocol for treating pneumonia in nursing homes
Focus 2. Vitamin D supplementation for nursing home residents
Focus 3. Providing palliative care in nursing homes
Focus 4. Multifactorial interventions to prevent falls in nursing homes
Focus 5. Good clinical practice guidelines on personalised health support for care home residents: resident-focused care coordination
Focus 5B. Good professional practice guidelines on personalised health support for nursing home residents: end-of-life care
Focus 6. Continuous quality improvement initiative
Focus 1. Developing a multidisciplinary protocol for treating pneumonia in nursing homes

**Principles**
A protocol is an aid to working in a coordinated and multidisciplinary team. It is drawn up by a team in the context of its working environment. To be effective and actually be used, it should meet the following criteria:
- The protocol is formalised around a simple objective.
- Up-to-date data from the literature are incorporated into the protocol.
- The protocol results in a multidisciplinary approach.
- The resources needed to implement the protocol have been made available (there is a named contact person for the protocol, set procedures for communicating information between professionals, and the protocol is available on site).
- Arrangements for monitoring and amending the protocol have been made (multidisciplinary meetings, follow-up indicators and feedback on professional satisfaction).

**Supporting documents that may help with writing a protocol for treating lung disease in care homes:**
- HAS key points sheet, February 2015: “Comment élaborer et mettre en œuvre des protocoles pluriprofessionnels ?” [How to draw up and implement multidisciplinary protocols].
- HCSP report, July 2012: “Conduite à tenir devant une ou plusieurs infections respiratoires aiguës dans les collectivités pour personnes âgées”.

Focus 2. Routine vitamin D supplementation for care home residents

**Principles**
- Offer routine vitamin D supplementation to all nursing home residents:
  - Also include residents who are confined to bed, receiving palliative care or have a short life expectancy.
  - Exclude residents at risk of hypercalcaemia.
- From admission and throughout the nursing home stay.
- No prior assay of vitamin D serum levels.
- Vitamin D3 preferred in cases of intermittent supplementation (longer half-life than vitamin D2).
- At a daily dose of 1000 IU and probably higher doses in residents who are obese or have dark skin.
- No monitoring with blood tests or adjusting the vitamin D dose. Check vitamin D serum level only if overdose is suspected.
- Intermittent supplementation at a dose equivalent to 1000 IU/day may be preferred: 100,000 IU every 3 months or 50,000 IU every month or equivalent. (Facilitates distribution by nurses and reduces the number of doses taken by the resident.)
- Oral calcium supplements should not be routinely prescribed. If calcium intake is less than 1200 mg per day, intake from food should be increased. If this is unsuccessful, a maximum supplement of 500 mg/day may be prescribed.

**Supporting documents**
Focus 3. Providing palliative care in nursing homes

The majority of nursing home residents are dependent, have multiple pathologies and have cognitive impairments. It is important to provide them with appropriate care that respects their quality of life and maintains their remaining independence.

1. Inform residents and their families of the possibility of drawing up advance directives and appointing a trusted person, as soon as possible after admission to the nursing home if their health permits.

2. Identify residents who require palliative care

Through structured interviews with residents and/or their families, conducted by a trained member of the nursing home’s healthcare staff, in order to identify residents whose goals, preferences and needs make palliative care appropriate, using the Ethical Reflection Tool by Sebag Lanoë if necessary, and inform the general practitioner.

3. Offer palliative care

- The general practitioner is informed that the goals, preferences and needs of their patient may make palliative care appropriate.
  - If the patient is able to express their wishes
    - The general practitioner talks to their patient, confirms whether or not palliative care is appropriate, and if applicable, plans recommendations with them regarding any limitations of care now or in the future (intensive care, intubation, artificial feeding, or hospitalisation).
    - These recommendations are added to the patient’s medical record by the general practitioner and summarised in the resident transfer form
  - If the patient is unable to express their wishes
    - With the help of the nursing home, the general practitioner organises a multidisciplinary team meeting, in accordance with the Leonetti Law, to decide whether the patient’s preferences and needs make it appropriate to stop or limit treatments and to provide palliative care.
    - The report from this meeting is added to the patient’s medical record by the general practitioner and the key points are summarised in the resident transfer form.

4. Assess the feasibility of providing palliative care in the nursing home

- Inform the patient and the family and support them with regular discussions
- Assess the resident’s care needs and need for aids, adapt their Individualised Patient-centred Care and obtain the resources necessary.
- Plan to use external palliative care resources:
  - Hospitalisation at home (HAH) if the criteria for this intervention are met.
  - Mobile Community Palliative Care Team (EMSP), palliative care health network, Mobile Community Geriatrics Team (EMGE).

5. Plan for and manage crises

- Guarantee continuity of care and 24/7 access to care
- Make the resident transfer form (DLU) accessible, with:
  - Identification of patients receiving palliative care
  - Advance directives
  - Family contact information
- Facilitate identification of patients treated by HAH, an EMSP or a palliative care network and hand over their on-call telephone number
- Facilitate the issuing of advance prescriptions for a named patient, by their general practitioner, for foreseeable emergencies
- Make it easier for families to support residents at the end of their life during the day and at night

6. Plan for hospitalisation when necessary

- With the general practitioner, arrange a direct admission, bypassing the emergency department, to an appropriate hospital department (geriatrics department with or without EMPS, identified palliative care bed (LISP) or palliative care unit (USP).

7. Reassess the situation regularly with the general practitioner, the resident and their family and adjust the interventions

Supporting documents:

- Outils de questionnement en équipe face à une situation gériatrique relevant de la Loi Léonetti, Groupe SFAR/SFGG [French Society for Supportive and Palliative Care/French Society for Geriatrics and Gerontology Group] – 2011 (reflection tool by Sebag Lanoë)

- Form to request hospitalisation in a palliative care unit:

Focus 4. Multifactorial interventions to prevent falls in nursing homes

A multifactorial intervention to prevent falls involves:

A multifactorial assessment aims to identify risk factors for falls, assess the risk of new falls and risks related to these falls (fracture risk, risk of loss of independence), and assess the individual’s need for aids. This assessment must include a functional capacity evaluation (walking, balance, transfers, and fatigability) performed by a physiotherapist and supplemented if necessary by an occupational therapist or psychomotor therapist.

A personalised treatment programme, drawn up based on the modifiable risk factors for falls identified in the assessment, which aims to reduce the risk of new falls and reduce risks related to falls.

Examples of actions in a multifactorial intervention to prevent falls:
- Vitamin D supplementation
- Nutritional interventions in case of weight loss
- Combating sedentary behaviour in everyday life through assistance from caregivers which respects the patient’s independence
- Promoting regular physical activity that is appropriate to the patient’s level of fragility and risk factors
- Reassessing treatments, especially psychotropic drugs, and favouring non-drug treatments for behavioural disorders
- Reassessing physical restraint
- Identifying vision and hearing problems and correcting sensory impairments
- Improving footwear
- Adapting the environment and making it safe
- Screening for and treating orthostatic hypotension

In patients who experience falls, rehabilitation and recovery treatment from a physiotherapist is almost always necessary, to correct weakness (e.g. strengthen the quadriceps muscles) and functional defects by working on balance and walking. This rehabilitation is performed in a way that reassures the patient. If the psychological impact of the fall is severe, supportive psychotherapy may be considered.

Walking aids are sometimes necessary. Patients should always be trained in how to use them by a physiotherapist or occupational therapist.

If there is a known risk of hip fracture, residents may be offered hip protectors.

To maintain the elderly person’s independence and/or reduce the risk of falls, additional support may be necessary: human assistance (physical assistance that respects the resident’s independence) or physical aids (adjustable beds, wheelchairs, transfer aids).

Key figures in the care home

The general practitioner and MEDEC have a central role in:
- identifying and assessing risk factors for falls;
- correcting previously identified risk factors;
- arranging access to additional specialist resources in the community or at a hospital.

The physiotherapist may, if prescribed by the general practitioner:
- assess functional capacity, postural stability and muscle strength;
- work on rehabilitation or recovery;
- advise on and prescribe walking aids and teach the resident how to use them.

The occupational therapist may:
- assess the resident’s functional capacity and the safety of their environment;
- advise on walking aids and teach the resident how to use them.

The IDEC, nurses and caregivers help to assess, monitor and assist the resident in their daily activities and to monitor treatments.

Supporting documents:

Cadre référentiel ETP Paerpa : Prévention des chutes [Reference framework on TPE for elderly individuals at risk of losing their independence: Preventing falls], HAS, Sept. 2014
Guidelines: Évaluation et prise en charge des personnes âgées faisant des chutes répétées [Assessment and management of elderly individuals with recurrent falls], HAS, April 2009.
Stratégie de prise en charge en cas de dénutrition protéino-énergétique chez la personne âgée], April 2007.
Focus 5. Good clinical practice guidelines on personalised health support for care home residents: resident-focused care coordination

1. ENSURE CONTINUITY OF THE RESIDENT'S MEDICAL CARE BETWEEN THEIR HOME AND THE NURSING HOME
   - As regards maintaining links with their general practitioner.
   - As regards maintaining links with any specialist physicians consulted outside the nursing home.
   - As regards returning home or transferring to another medical social organisation.

2. COORDINATE CARE PROVIDED WITHIN THE HOME WITH GENERAL PRACTITIONERS
   - Make general practitioners aware of the different sections of their patients' individualised care.
   - In the nursing home’s plan, specify the procedures for reporting complaints and sending them to the general practitioner.
   - Specify how information will be shared between the general practitioner and the team.
   - Specify how information will be sent to the coordinating doctor.

3. COORDINATE THE RESIDENT’S MEDICAL CARE WITHIN THE NURSING HOME WITH THE MOBILE GERIATRICS TEAM (EMG) AND/OR HOSPITALISATION AT HOME (HAH) SERVICE
   - Draw up an operating agreement after defining with professionals the need for collaboration, options and limitations of each party.
   - Arrange how information will be sent and shared between professionals in the team or HAH service and professionals who support the resident on a daily basis.
   - Assess this partnership annually.

4. COORDINATE TREATMENT WITH OTHER ASPECTS OF SUPPORT, INCLUDING IN ACUTE MEDICAL SITUATIONS
   - Inform non-healthcare professionals and volunteers involved in the individual’s care plan of problems related to changes in their health.
   - Make arrangements, where possible, to allow the resident to continue with their plans.
   - Assess and adapt responses at every multidisciplinary team meeting.

5. GUARANTEE CONTINUITY OF THE RESIDENT’S CARE BETWEEN DIFFERENT UNITS IN THE NURSING HOME
   - Explain to professionals, residents and their loved ones the specific roles and admission criteria for each individual unit and how each unit is run.
   - Keep a single file for the resident throughout their stay.
   - Arrange for observations to be sent from one unit to another.

6. PLAN HOW TO MANAGE MEDICAL EMERGENCIES
   - Train professionals in emergency situations.
   - Analyse problems regularly to ensure, in particular, that emergency hospital admissions are only due to genuine medical emergencies.
   - Inform professionals of individuals who are likely to end up in an acute situation.

7. ESTABLISH LINKS WITH THE HOSPITAL IN CASE A RESIDENT IS ADMITTED
   - Keep the resident transfer form (DLU) up to date.
   - Determine how the resident’s file will be sent from the care home to the hospital.
   - Plan to organise their return from hospital.
   - Analyse hospital stays.
   - Obtain feedback from residents and their loved ones on hospital stays and returning to the nursing home.
   - Offer regular meetings between the coordinating doctor and the departments involved.
Focus 5B. Good professional practice guidelines on personalised health support for nursing home residents: end-of-life care

1. SUPPORT THE RESIDENT

Before the end of their life
- If possible, broach the subject of their death with them.
- Do not conceal the death of other residents.

At the end of a resident’s life
- Every day, assess their needs and expectations whether on a physical, psychological or spiritual level, and discuss what to do with the general practitioner.
- Where necessary, call upon the mobile teams and resource people available.
- Every day, assess the nursing home’s internal resources and whether they are able to ensure the individual remains comfortable at all times, including at night.
- Set out the alternatives to the resident if they are able to listen, to their families, and where applicable to the trusted person.
- Organise a meeting between all individuals concerned with a multidisciplinary reflection procedure on the appropriateness of pursuing one treatment or another, and of transferring the resident or not, allowing the general practitioner to make an informed decision.

2. SUPPORT FAMILIES
- Keep close family and friends informed of the resident’s health status, of treatments started and their aims.
- Discuss with them any wishes expressed by the resident regarding the end of their life, or obtain their opinion if this subject could not be broached with the resident.
- Discuss the resident’s level of comfort with them.
- Find out what role they would like to play in caring for their relative during their last moments.
- Take care of material arrangements so that families who wish to care for the resident can do so.
- Offer whatever help is available to support them through their emotional suffering and thus help them express how they feel.
- Continue to provide support “after death”.
- Inform them if some of the residents and/or professionals wish to be involved in the funeral and ask them for their opinion.

3. SUPPORT/ASSIST PROFESSIONALS
- Include a palliative care section in the care home’s plan which defines the options, limitations and procedures for working together with local organisations and resources.
- Include training on palliative care and end-of-life care in the continuing professional development plan, covering assistance, verbal and non-verbal communication, multidisciplinary working and stress management.
- Once or twice a year, arrange an analysis of end-of-life support practices.
- Arrange support for professionals after the deaths of residents.

Focus 6. Continuous quality improvement initiative

**Example of using indicators to implement new preventative actions**

For several years, nursing homes have been included in a continuous quality improvement initiative (tripartite agreement, internal and external assessments). As part of this, they have drawn up improvement action plans.

To follow up this initiative, nursing homes are attentive to changes in their residents’ needs and expectations, their resources and their practices. They may use indicators to help them identify, from simple observations and taking the context into account, whether the quality objectives for care are present and correct in the nursing home.

The indicators in this file can be used to identify whether the quality objective for reducing inappropriate or potentially avoidable hospital admissions is present and has been taken into consideration in the nursing home.

For example, a nursing home has noticed an increase this year in emergency hospital admissions throughout the influenza epidemic (an increase in the number of falls). Next autumn, the management and healthcare teams plan to organise a health promotion campaign among staff, residents, residents’ families and volunteers on simple actions they can take to protect themselves from influenza and to protect others:

- flu vaccinations for residents and healthcare staff;
- standard precautions (hand washing and alcohol gel);
- additional “droplet” precautions;
- building on the national campaign for flu vaccination.

**Supporting documents:**


All of these documents are available for download from [www.anesm.sante.gouv.fr](http://www.anesm.sante.gouv.fr)