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Health Care Services for UK Care Homes

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Workstream 1: towards improving the care of people with mental health problems in general hospitals. Development and evaluation of a medical and mental health unit.

Workstream 2: Development and evaluation of interface geriatrics for older people attending an AMU

Workstream 3: Development and evaluation of improvements to health care in care homes

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Health Care Services for UK Care Homes

Summary

In a consultation event of UK care home managers and health care providers:

- Care home managers expressed a desire for rapidly responsive medical support from GPs
- Care home managers expressed concern over their relationships with secondary care, in particular regarding discharge arrangements
- Care home managers expressed satisfaction with rapidly responsive support from non-medical services such as rapid response teams, advanced practitioners and paramedics (the latter being particularly appreciated out of hours)
- Health services for care homes appear disorganised, in that care home staff are not fully aware of the services that are available, and they report that access to those they know about can be illogical and inequitable. As result, ad hoc arrangements can develop, and these are vulnerable to breaking down.
- Improvements to the delivery of GP cover by the use of the preferred practice model could be part of the solution, as could the use of rapid response teams, nurse practitioners, or paramedics, but the cost effectiveness of these developments is not yet known.

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Introduction

The overall aim of the Medical Crises in Older People care home workstream was to improve the quality of health care to care home residents. The care home workstream initially comprised the following research elements:

- A cohort study of residents of a representative sample of care home residents, to describe their health, changes in their health, and their health resource use
- Literature reviews of guidelines and protocols for health problems in care home settings, and of the RCT trial evidence in the care home setting
- An interview study of a variety of staff involved in the health care of residents of care homes

This research was undertaken in Nottingham and Nottinghamshire. One of the tasks of the workstream was ensure that the research was embedded and grounded in clinical practice. This was for important practical reasons:

- Any clinical research requires the willing and constructive assistance of those involved. Clinicians need to see the purpose of the research and how it might help them deliver better care
- Pragmatic clinical research wishes to test interventions in naturalistic settings, so that the findings can easily generalise to ordinary practice elsewhere.
- The success of interventions requires an effective response of the whole health care system.

This research not only needed to embed itself in clinical practice, but to help optimise it.

This report describes and reflects upon a meeting organised by the MCOP Care Home workstream on 30th September 2009, attended by staff from care homes in Nottingham and Nottinghamshire and health care providers and commissioners from two organisations responsible for local health care delivery (Nottingham City and Nottinghamshire County Primary Care Trusts (PCTs)).

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Care homes in the UK are small by international standards (average size around 20 residents) and, for the most part, do not provide health care services themselves – they are social care institutions with a remit focussed specifically around residential and day-to-day nursing care. Primary health care is typically provided from the local General Practice surgery with whom each resident is registered. Field work done in the course of the Medical Crises Care Home workstream had revealed that there were also many PCT-level services for the care home sector. These included:

- an urgent response nursing and allied health professional service provided by the Nottingham out-of hours service provider
- a nurse practitioner for homes with apparently high hospital admission rates or referral regarding safeguarding
- pharmacists to support both medication reviews with GPs and medicines management in homes
- occupational therapy services, such as for aids and appliances
- physiotherapy
- continence promotion
- dietetics
- end of life care
- tissue viability
- falls prevention.

Other services from outwith the PCTs had also been developed such as a dementia support team provided by the local provider of specialist mental health services (the Nottinghamshire Healthcare Trust). The PCTs were aware of the need to integrate and more equitably deliver these services, but uncertain of how to do so, not least because of the absence of clear evidence to guide practice. Contact between the PCTs and the care homes themselves was relatively limited to individual clinical contacts, or on matters relating the safeguarding of individual residents. The PCTs felt that an opportunity to discuss their plans and establish views of the care homes staff would be

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helpful. Field work also indicated that the care home sector felt vulnerable, avid for help, and sometimes not listened to. They too were keen to participate in an exercise where they could discuss health care support with commissioners and providers. The aims of the research would require, as a starting point, the optimisation of existing health care services. Thus this meeting was important for all parties involved: health staff, care home staff, and researchers.

Method

A decision was made, for this meeting, to invite

- PCT staff having a remit for the commissioning and delivery of health care services to care homes
- care home staff, identified from a database of 120 registered care homes within a 10 mile radius of the University of Nottingham.

General Practitioners were not specifically invited. This was partly a practical one because it is difficult to get GPs to a meeting, but mainly to keep the focus on the broader health care needs as opposed to those met by a GP. Issues about the relationship between PCT provided and GP-provided health care to residents of care homes have been discussed in Issue 1 of this series[1] and are touched upon again in the Discussion section of this paper.

The meeting was attended by 24 staff from care homes, 14 NHS commissioners or providers, and 15 research staff as facilitators. The meeting was held in a large lecture hall, with tables set out in "cabaret" style – 6-8 chairs arranged around small tables. Lunch was provided, following which a short introduction was given, and then an educational session on the management of sleep in care homes based on the MCOP literature review[2]. This was followed by a brief summary of the MCOP care home workstream progress, and then the session reported in this paper was introduced. Delegates were asked to arrange themselves on tables to create a mixture of care home

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staff and health care staff. A facilitator was nominated for each table. Each table was asked to do the following:

- NHS staff were to describe to care home staff what services they provided and were developing, and to invite care home staff to comment
- Care home staff were asked to identify what services they would like, what services they currently found helpful, and what wasn't working well

The facilitator was asked to record notes on the discussions and report on behalf of each table examples of services that were helpful and areas where they still had problems.

The notes taken by the facilitators and by MCOP care home staff were used in the preparation of this report. The facilitators' notes were typed up by a research secretary, and organised by the authors into topic areas.

Results

About General Practitioners

Views about General Practitioners (GPs) were mixed, with positive and negative experiences and instances listed. Care home staff reported that they preferred to have a single GP to deal with, rather than many, for most clinical contacts. They also wanted to have immediate access to a doctor. A model that was described favourably for day-time GP care was where GP practices used a nominated on-call GP for the day who was available for urgent calls on behalf of all the GPs in the practice (many GP practices in the UK have several GPs working together). Access to immediate input was more important than having access to the same doctor every day, or each resident's own GP. Such doctors could be contacted by telephone in the event of a minor issue for advice or reassurance.

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Negative aspects of GP care included when the reverse of the above was observed, for example when care home staff had to relate to multiple practices, found it difficult to get through to the surgery, or had to wait until the GPs could find time to respond.

Another negative point made by care home staff regarded medication reviews. A number of managers suggested that these reviews did not occur as frequently as they should (6 monthly is expected) or were thorough enough. It may be that they were not aware of reviews done by GPs, or that routine medication reviews are not as helpful as event-driven reviews, or they may be right. Managers seemed particularly concerned by the issue of polypharmacy – with the addition, or escalation, of drugs at medication review attracting particular criticism.

Access to health care services is sometimes via the GP, and sometimes care home staff have direct access. It was expressed that having the GP as the gatekeeper for other services had problems given the perceived problems in timely access to GPs. Care home staff expressed their view that this was a mechanism to ration services unfairly in an attempt to reduce costs. Accordingly, there was a preference from care home staff to have direct access to services without having to go through GPs. The manager of one home reported that she was able to access a number of services informally (dietetics and physiotherapy were the examples quoted) by using long-standing personal relationships with allied health professionals to subvert formal referral pathways. It was also pointed out that some arrangements for access to services were illogical and counter-productive. For example, the manager of one dually-registered home noted that she could directly access specialist nursing services for her residential clients but the same services could only be accessed via the GP (and hence delayed) for her nursing clients (due to the expectation that nursing homes should provide nursing care). On occasions the manager had to decide whether to keep a resident on the residential side of the home (losing income, and potentially jeopardising their care) simply to ensure that they could get rapid access to the specialist services she felt the resident needed.

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Note that GPs were not present at this meeting to put forward an alternative perspective, and hence this represents the perspectives of the care home managers only. PCT staff by and large did not contribute to this area of discussion.

Secondary care

Views of secondary care by care home managers were largely negative: they did not seem to be constrained in their complaints by the presence of secondary care staff in the room. Their concerns related to poor discharge communication, and a perceived lack of understanding of the role of care homes – such as the distinction between a care home with or without nursing and the limited capability of the latter. Care home staff reported that hospital staff frequently appeared arrogant in telephone conversations, for example when simply telling the care home staff that a patient was to be discharged without discussion, or being reluctant to answer questions about the resident's well-being and function. Sometimes during such communications, care home staff felt that hospital staff (nurses) appeared indifferent to the care needs of the residents, something they found even more shocking and unprofessional. Care home staff reported that residents frequently returned to the home in a state quite different from that described over the phone and, as they judged, with many aspects of basic nursing care poorly attended to. Not only was this seen as an issue of lack of respect for dignity, in some instances urgent action was needed (such as organisation of specialist pressure care) to avoid yet another clinical problem or re-admission as a result. A particular area of concern for managers was what they perceived as inadequate pressure area care in the acute hospital setting – with the assertion that this contributed both to patient suffering and the care home workload considerably. It was clear from these statements that the respondents in this event took their professional and caring roles extremely seriously and passionately.

Not all contacts with secondary care were like this. Although far from routine, timely, legible and informative discharge letters when received were helpful. No views from

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secondary care nursing were available at this meeting to provide an alternative perspective.

Overwhelmingly, managers of care homes in this meeting wished to keep their residents in the care home where possible, and this was justified on the grounds that they felt they could provide better care and give the resident a better experience for doing so. However care homes without nursing expressed extreme vulnerability when faced with medically unstable residents, particularly as they were not staffed or authorised to deal with the issues. They welcomed services that could enable them to care for their resident's in-situ.

Other services

Many care homes found the paramedic service helpful, and some used it often. It was responsive (via a 999 call), and the paramedics were well trained medically, fully able to act independently without calling for a GP or transferring to the hospital emergency department. Many such paramedics were apparently comfortable with not transporting the resident to hospital, thus enabling their on-going care to be provided in the home. The paramedic service was more responsive than the usual out of hours GP service, and appeared to be used in some cases instead of the GP during ordinary office hours as well.

PCT staff were uncertain how to interpret these observations, as they were unsure whether it was appropriate for the emergency ambulance service to be used as a rapid response service providing an alternative to ordinary primary care.

District nurses were deemed extremely valuable. They tended to visit care homes without nursing to see specific patients such as to give insulin to diabetics, rather than as a specific service to the home. However, having visited the home, they tended to be asked to advise regarding a variety of other health matters. Since visits to give insulin were daily, this provided an acceptable, daily, skilled service, and would provide links to

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the GP. It was noted that homes with residents without such needs would be unlikely to receive such a service. District nurses would not visit a care home with nursing for such purposes, and so would not provide a link to the GP.

Difficulties in accessing dental services were mentioned. Most care homes residents require an escort if they have to travel to the service (as an ordinary community-dwelling person would be expected to do). This is often not easy for care homes where staffing levels are tight. For people with poor mobility without a family member of volunteer to assist, the logistics of visiting a dentist or similar service can be considerable and sufficient to defeat the purpose. Presumably this problem with access to health care might apply to other health services not providing a visiting service, although other services were not discussed in the event.

Special services

One local service praised by those homes that had contact with it was a rapid response nurse and allied professional team provided by the Nottingham City PCT, via a contract with the out-of-hours service provider. This service could be reached by phone during working hours, and could obtain advice or summon a nurse on the same day. Minor injuries or practical advice, or referral to other agencies could be facilitated by this team.

Several homes felt that the increased public and policy profile of end of life care matters had led to recent improvements in terminal care: access to syringe drivers and experience in their use was reportedly more widespread than a few years ago. It was suggested that it was easier to keep people in the care homes when such services were provided. Care home managers however still reported instances when such services were not available, leading to admission to hospital for the needs of such dying residents to be met, also indicating patchy implementation of this provision within the district nursing service.

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Another well–considered example of a specialist service was given of a community matron who had been assigned by a PCT to a care home identified to have high rates of use of hospital and emergency care. Details of how these rates were rapidly reduced were not discussed in this meeting, but high satisfaction from the matron (who was present) and the home she had intervened in (staff from which were also present) was reported.

Access to services

Several matters relating to access to services came to light during the meeting:

- Even in this self-selected population, many care home managers were unaware of the range of services that were available to them
- Many care home managers and commissioners were troubled to note that different services were available in the two PCTs
- Managers reported illogical referral routes that depended upon the registration status of the resident (residential or nursing) as opposed to their clinical need and were not uniformly applied across residents within the same home, given that they were often covered by different GPs.

There was widespread agreement that clear and common pathways for referral were required, which should be similar between the two PCTs to avoid ambiguity or inequity. There was general support by managers for direct access to services, rather than via a GP. This could be via a rapidly responsive single point of contact such as a district nurse or advanced practitioner.

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Anecdote: the consequences of ad hoc services

A residential care home manager regaled the following tale. She was on holiday in France when one of her residents, an elderly ex-military man with dementia, started to become agitated. He was known to be prone to occasional outbursts especially when thwarted – he sometimes believed that the care home was or should be under his control, that being related to royalty he should be obeyed, or that certain ladies (staff and residents) should do him sexual favours. On the day in question he had started to bang his walking stick on the table in frustration, but eventually he clumsily injured his hand on the edge of the table, and it bled profusely.

The staff member in charge took some advice from the manager by telephone and was advised to ask if the local practice nurse could assist, as an informal relationship had sprung up. This was not the usual nurse, and her attitude towards providing assistance was unhelpful, quite unlike that of the usual nurse. By this point the resident had become even more agitated and blood stained. After further advice from the manager in France, the paramedics were called. On this occasion, they did not have any adhesive wound closures and so suggested removing the man to the emergency department of the local hospital so that he could have his wound dressed there. However, this alarmed the gentleman even further, and so he waved his walking stick yet more and threatened the (uniformed) paramedic. It was reported that the paramedic then decided to phone the police, as it appeared that here was a man using an "offensive weapon". Telephone discussion with the police then took place about whether he might require sectioning under the Mental Health Act. Eventually the resident settled down, and more simple steps were taken. Throughout all this, the care home manger was kept informed, racking up a £70 mobile phone bill. It was noted that similar episodes to this, both before and since, were managed by quiet non-confrontation between the care home staff and district nurses.

The tale has the feel of the plot of a TV sit com, where an almost trivial issue was escalated through mismanagement to absurd proportions. It illustrates the fragility of a system depending upon the dependence in small care homes upon the availability of skills in social care staff and the ad hoc provision of support services, the importance of which are only revealed when they are not available. It also illustrates the tendency, in the absence of the provision of expertise in the community, to drive patients towards the hospital based system.

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Discussion

The main points from this exercise were that:

- Access to and use of services was highly variable
- Services varied between PCTs
- To keep a person in a care home and avoid unnecessary referral to secondary care, services must that available that are immediate, that visit the home and that are sufficiently skilled to meet needs of the residents
- Such services should recognise both the vulnerability of care homes without nursing, which rely on the informal health care skills of social care staff
- Such services should recognise the vulnerability of care homes with nursing, which might be assumed to provide more health care expertise than they do

Staff in UK care homes without nursing have to deal with people who have a large number of low level health problems. They are not simply older people requiring board and lodgings. Even in non-dementia homes, many residents have long term conditions including dementia and hence have specialist needs. And yet, they are typically staffed by people who do not have the qualifications or authority to deal with such a ground swell of symptoms – although many care home managers have a wealth of informal or previous health care experience. The managers of these homes could either ignore these issues or attempt to deal with them in-house (in which case they could be accused of neglect or not recognising their limitations) or they could use any service they could find that works – this could be an on call GP, the emergency ambulance service, telephone services (such as "NHS Direct"), amenable district nurses, community matrons, or other specific services. The choice of which services is used is driven partly by habit and custom, partly by individual actions, and partly by availability of the GP. It is not driven by research evidence of cost-effectiveness, and neither are there clear clinical pathways.

There are important strategic issues. To what extent should GPs and GP practices be responsible for the health care needs of care home residents and to what degree should

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services be provided by the PCT? What are the relationships between their responsibilities? What, of the available options, is the preferred first line contact for care home staff on behalf of residents with minor medical problems, in and out of hours?

In Discussion paper 1 of this series[1], it was argued that one important step in the rationalisation of health care for care homes would be to move towards a preferred practice model, whereby most residents in a home would receive primary care support from one practice (which would usually be from one GP in the practice). This view is compatible with findings of this consultation exercise, although it is not clear, whether a preferred practice model would necessarily provide an immediately responsive service. It could, if an on call GP were available. Such a model would not deal with health care out of usual surgery hours. Alternatives, such as advanced practitioners and emergency support services, unless very intensively resourced, would also not provide a solution to out of hours provision. It is not clear whether better provision of care in working hours, dealing with problem in an anticipatory manner would reduce the need for out of hours care. More information on the working of rapid response teams and nurse practitioners schemes is required.

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