Enhanced Care in Care Homes

Dr Jane Halpin- GP partner in Sunderland
GP Care Home Lead for Sunderland CCG

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Take Home Messages

- Importance of Team working and Relationship Building

- Importance of robust and honest Advance Care Planning

- Care Homes can be really nice places to work from

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Why bother with Care Homes?

- Because there are an awful lot of really complex people in them who need excellent care before they die.

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Here!

What Sunderland do

- GPs - practices aligned to care homes

  regular on site MDTs

  Advance care planning

- Care Home Nurse team
- Secondary care- A and E frailty nurses who can ‘turn round’ suitable patients

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Family/POA
/IMCA

GP

Care
Home
Staff

Patient

Dietician

Care
Home
Nurse

Admin

Podiatry

CPN

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Who to discuss?

- **Any new resident**
- **Any one discharged from hospital**
- **Any one with acute problems**
- **Anyone who has family there and they want a chat**
- **….any deaths**

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What does the MDT do?

- **‘Enhanced Care’**
- **Promotes Individualised Dignified Care**
- **Proactive not reactive**
- **Sensible, pragmatic, realistic**
- **Facilitates CGA**
- **And……(most importantly)…..**

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…forms relationships and builds trust

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Advantages of Care Home Medicine

- **Stable environment- social variable can be taken out of the equation**
- **Most of the time the residents are well!**
- **Treatment alterations/deprescribing can be easily monitored and adjusted**
- **Staff are generally a very motivated and caring lot**

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Comprehensive Geriatric Assessment

- **Focused on;**

- **Capacity assessment**

- **Medication reviews and deprescribing**

- **Advance Care Planning**

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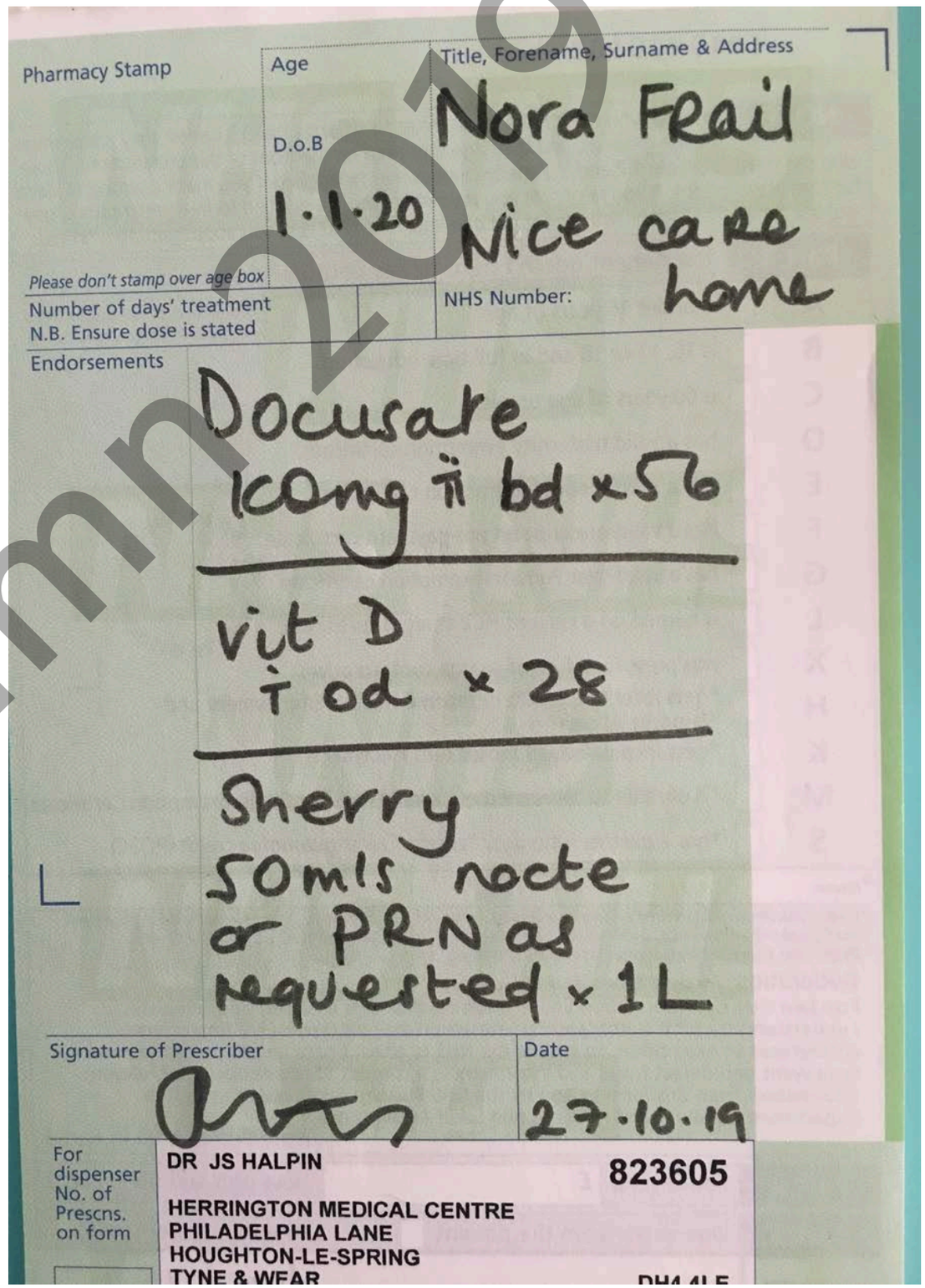
Deprescribing

Always a joint effort with the patient

Tends to focus on falls risk

Statins
Amlodipine
Bendrofluazide
Adcal
Donepazil
Etc etc etc


Pharmacy Stamp

Age

D.o.B

1·1·20

Title, Forename, Surname & Address

Nora Frail

Nice care home

Please don't stamp over age box

Number of days' treatment
N.B. Ensure dose is stated

NHS Number:

Endorsements

Docusate
100mg ii bd x56

Vit D
1 od x28

Sherry
50mls nocte
or PRN as
requested x1L

Signature of Prescriber

Date
27·10·19

For dispenser No. of Prescns. on form

DR JS HALPIN 823605

HERRINGTON MEDICAL CENTRE
PHILADELPHIA LANE
HOUGHTON-LE-SPRING
TYNE & WEAR

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Noreen

- 78 - discharged to residential care from hospital after MI
- Bipolar(lifelong) MI x2 T2DM(insulin) AF COPD
- Capacitated. Continent. Zimmer
- ISMN, dig, atorvastatin, apixaban, Nicorandil, furosemide, metformin, gliclazide, aripiprazole, mirtazepine, aspirin, docusate, lansoprazole, paracet, Gliclazide, Lithium, +inhalers + Lantus daily
- 36 tablets daily
- Had repeatedly asked to stop meds

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Advance Care Planning

- All documents taken from the Northern Cancer Alliance ‘Deciding Right’

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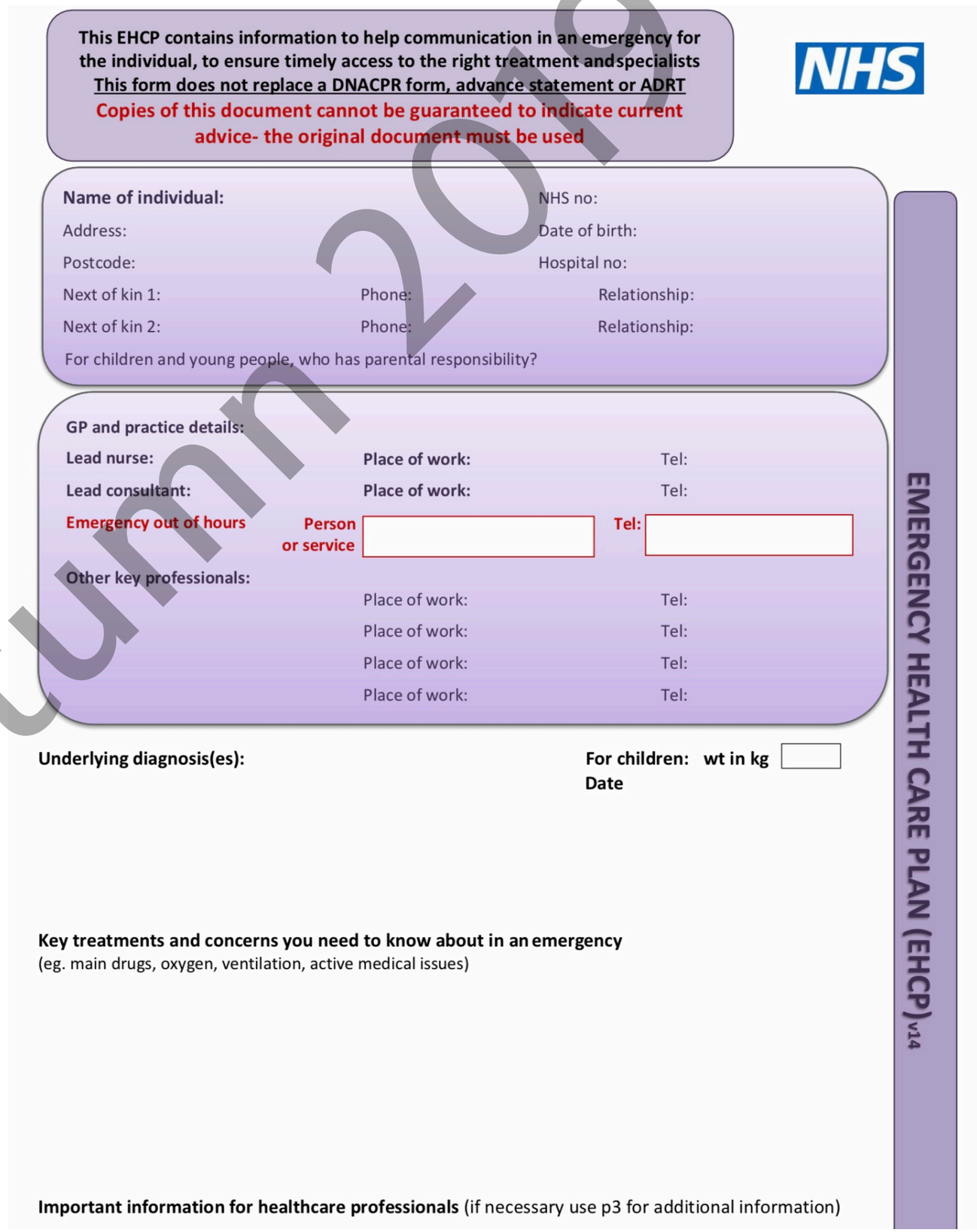
Emergency Health Care Plans

Individualised

Specific enough to be useful

Broad enough to cover random acts of illness

Absolutely NOT a 'do not admit' document



This EHCP contains information to help communication in an emergency for the individual, to ensure timely access to the right treatment and specialists
This form does not replace a DNACPR form, advance statement or ADRT
Copies of this document cannot be guaranteed to indicate current advice- the original document must be used

NHS

Name of individual: NHS no:
Address: Date of birth:
Postcode: Hospital no:
Next of kin 1: Phone: Relationship:
Next of kin 2: Phone: Relationship:
For children and young people, who has parental responsibility?

GP and practice details:
Lead nurse: Place of work: Tel:
Lead consultant: Place of work: Tel:
Emergency out of hours Person or service Tel:
Other key professionals:
Place of work: Tel:
Place of work: Tel:
Place of work: Tel:

Underlying diagnosis(es):
For children: wt in kg
Date

Key treatments and concerns you need to know about in an emergency
(eg. main drugs, oxygen, ventilation, active medical issues)

Important information for healthcare professionals (if necessary use p3 for additional information)

EMERGENCY HEALTH CARE PLAN (EHCP) v14

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EHCP example

Underlying diagnosis(es):

For children: **wt in kg** **Date**

vascular dementia- lacks capacity to make decisions regarding place of care
prine to UTIs- on prophylactic trimethoprim
prostate cancer- polyuria. zoladex injections 3 monthly
generally quite settled, but can be feisty! is mobile with zimmer
best interest decision been made with full discussion with Gail

Key treatments and concerns you need to know about in an emergency
(eg. main drugs, oxygen, ventilation, active medical issues)

Best interest decision has made to stay at the Lovely care home and be nursed here- unless fracture suspected- see over

Important information for healthcare professionals (if necessary use p3 for additional information)

DNAR in place (put in place on last hospital admission)
preferred place of death- The Lovely Care Home

TH CARE PLAN (EHCP) v14

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Important bit

Anticipated emergency(ies)	What to do
	TREATMENT GOALS ARE COMFORT, DIGNITY AND SYMPTOM CONTROL, NOT PROLONGATION OF LIFE. if the situation is not clear or complex- please discuss all treatment decisions with Gail - daughter
BLACKOUTS/SUSTPECTED STROKE	ensure comfort, for review by clinician. not for hospital transfer
FALLS	will need casualty assessment if a fracture is suspected. not for admission for head injury.
INFECTION	oral antibiotics are the ceiling of care ensure comfort and hydration- push fluids if possible.
URINARY RETENTION	Seek support from district nurses
	Please use common sense in all treatment decisions. Bob is a frail, demented, 90 year old man with prostate cancer who is wanting to spend his final days in a comfortable environment. It may be that Palliative Care becomes appropriate to facilitate this.

EMERGENCY HEALTH CA

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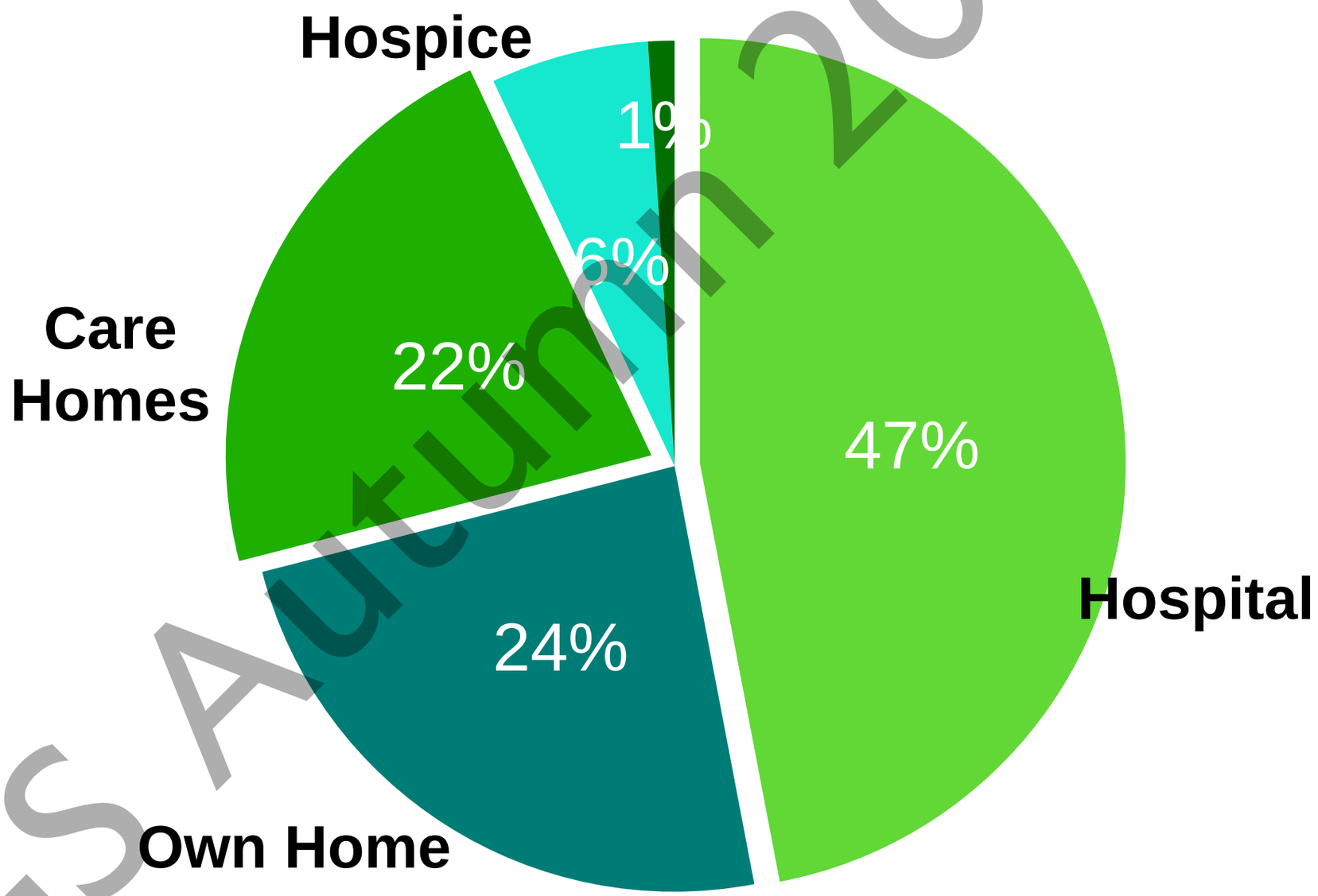
Does this model work?



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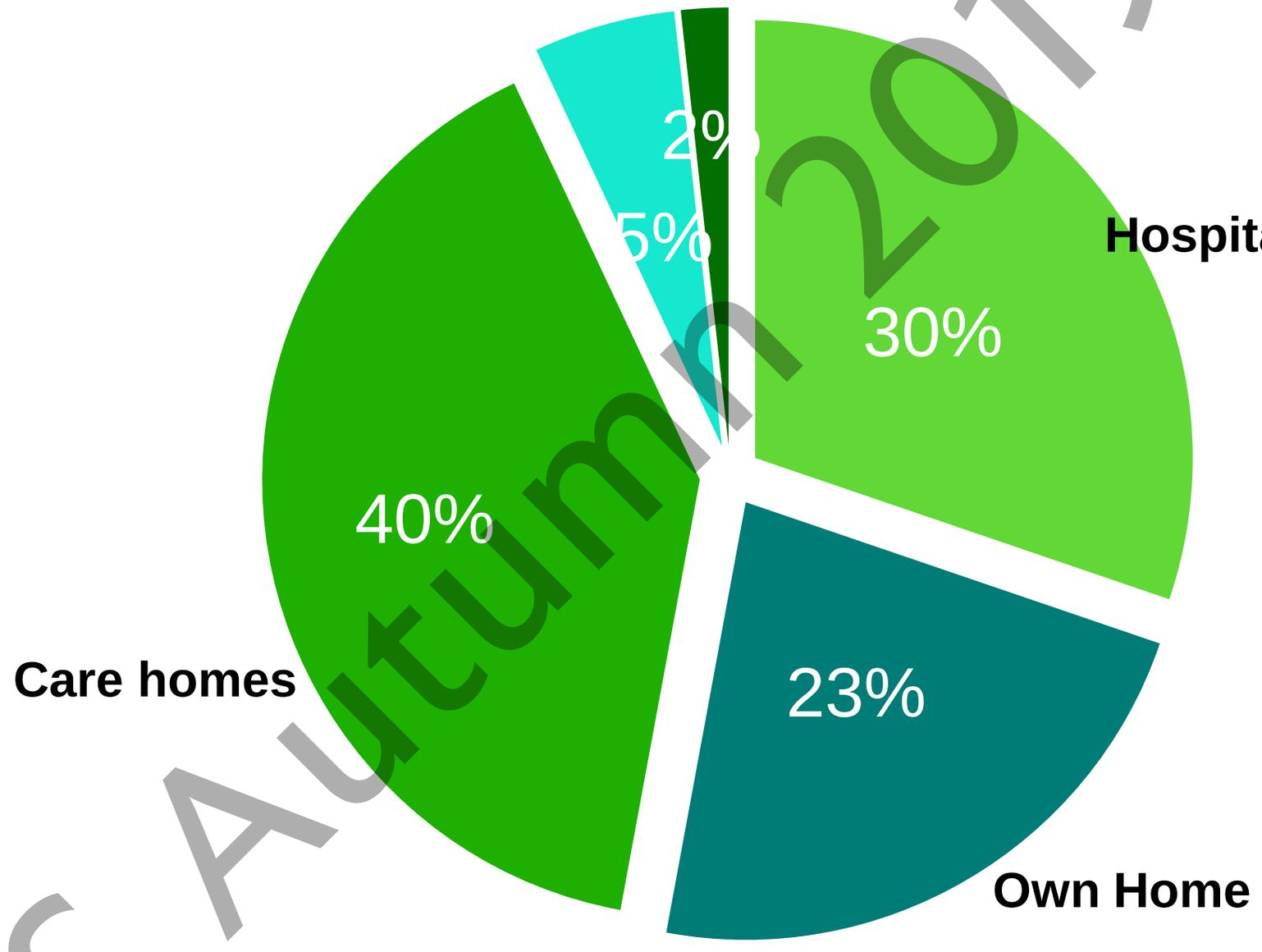
- **National data place of death 2016**



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Herrington Data- all deaths from 1.1.2018

- **75 residents from care homes died since 1.1.2018**
- **69 died in their care home (their preferred place of death)**
- **Of the remaining 6**
    - **3-family members had wanted very active hospital treatment**
    - **2-warrented admission due to potentially reversible causes**
    - **1- complete disaster and shouldn’t have happened**

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Anna

- **90 Nursing Care long term**
- **Advanced vascular dementia. DM. recurring leg cellulitis. CKD**
- **Hated hospital. EHCP and DNAR in place. Long chats with family. Best Interest decision made- stay put**
- **Legs break down (again). I'm on hols. Seen by another GP who wants biochem done prior to opiates (4pm)**
- **OOH Lab ring 111 with highish potassium – 111 ring 999. Staff in home try to keep her where she is.**
- **Paramedics tell daughter 'your mum will die if she's not admitted'**
- **Anna is admitted- Dies 2 days later on ward**

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Anna-lessons learnt

- **EHCP should have included ‘Don’t do bloods’**

- **If you must do bloods- don’t do them in the afternoon**

- **Family should’ve been told that death is a likely outcome wherever she was cared for.**

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Challenges

- Time
- Acute aggression
- Anxiety or inexperienced staff

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What I've learnt

- Being practical, kind and honest trumps being clever
- Don't do tests that you wont act on- **have an honest conversation instead**
- You have to talk about death clearly
- As a senior clinician, you have to take responsibility for a plan. Don't rely on someone else to make a difficult decision in a time of anxiety and stress. Be specific.
- Take the time to make relationships and build trust

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