

# Effective healthcare for older people living in care homes

## Guidance on commissioning and providing healthcare services across the UK

### Introduction

This **British Geriatrics Society (BGS)** is the professional membership body of specialists in the healthcare of older people in the United Kingdom. Our mission is to improve the healthcare of older people throughout the United Kingdom (UK).

This guidance was first published in 2011. We have updated it to ensure that new references and resources published since then are included. It sets out the clinical and service priorities for best practice, the outcomes that can be expected from following best practice, and some of the ways in which these can be achieved. It is for use by commissioners, policy makers, service providers, and for anyone with an interest in ensuring that older people living in care homes (residents) have access to healthcare that meets their needs.

In the UK 405,000 older people (65+) currently live in care homes. This represents 16% of older people over the age of 85. The term care home includes homes both with and without nursing provision. Data from population and cohort studies suggest that older people living in care homes have complex healthcare needs. The average care home resident has multiple long-term conditions, functional dependency and frailty. 75-80% of those people living in care homes have cognitive impairment. Residents are likely to have better health outcomes if health services reflect these needs, with attention to comprehensive, multidisciplinary assessment, case management and input from appropriately trained specialists in care of complex medical problems in later life.

In 2011 BGS published its report *Quest for Quality* which makes recommendations for how care home residents' quality of care can be improved, and we continue to promote these. [www.bgs.org.uk/index.php/resources-6/bgscampaigns/carehomes](http://www.bgs.org.uk/index.php/resources-6/bgscampaigns/carehomes).



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#### 1 Why are specific services important for older people in care homes?

**Health needs are complex** and most residents have multiple long term conditions, significant disability and frailty which affect both their physical and mental health. Dementia affects the majority of residents in care homes to some degree, and depression is common.

**Disability from late stage conditions** is complicated, for example in neurodegenerative conditions including Parkinsonism, dementia and severe stroke. Care home staff need support and training from health professionals to identify, understand and respond to the everyday impacts of providing essential care. This includes providing the right types of food and drink, preserving skin integrity and preventing contractures (shortening of muscle tissue). Medical treatment requires a systematic approach and attention to detail, which can be difficult for GPs to deliver under existing time and resource constraints. Some medical treatment may need specialist support from geriatricians.

**Person and relationship-centred models of care** are needed for people who have co-existing, late stage, diseases. Disease based models are insufficient. An individualised approach which addresses shorter term priorities of alleviating symptoms may outweigh the longer term value of disease control. Frailty and age have a significant impact on a person's response to drugs so that the burden and risks of adverse events may be increased. Community pharmacists and specialist nurses play a key role, but it should be recognised that an individualised model is needed and adherence to standard protocols is not enough to meet the needs of older people living in care homes.

**Standard services do not provide sufficiently accessible support** because access to GP surgeries and outpatient clinics is difficult and less effective than assessment and care planning that takes place in the care home. Out of hours services are often unable to access sufficient information to help decision making which supports continuity of care.

This can result in the overuse of hospital attendance and admissions. There is wide variation in levels of access to community-based therapies, and waiting times are variable and often long.

**Support from geriatricians can enhance the effectiveness of interventions.** There is evidence that the inclusion of geriatricians, where they are available, in the care home support team enhances the effectiveness of health and care outcomes for care home residents.

**Access and advocacy** is key as older care home residents are unable to initiate their own access to doctors or community healthcare. This means that care home staff must become both advocates and facilitators, and have the skills needed for that.

**A reactive approach is not enough.** Proactively establishing the objectives of care is the basis for success. This means a pro-active and planned approach should be in place from the outset, when an older person first moves to a care home. Palliative approaches may be needed from the time of admission, or the balance of approach may need to change over time. Patient- and relationship-centred health care and support plans are needed and should include advance care planning.

**Integrated provision** is required to meet the needs of care home residents who require co-ordinated input from generalists and specialists in multiple disciplines, in partnership with social care professionals and care home staff. Partnerships are essential to integration, and need to build on shared goals, reliable communication and mutual trust.

## 2 What are the benefits of specialist commissioning?

### For older people themselves

- Improved experience through high quality essential care, resulting in reduced distress from depression, disorientation, agitation, pressure sores, muscle contractures, constipation, pain and sleeplessness
- Minimisation of predictable acute events such as urinary infections, aspiration and pneumonia
- Avoidance of unnecessary progression of long-term conditions, coupled with a reduction in adverse drug events and the unnecessary burdens of irrelevant treatments
- Reduced risks of falls, fractures and other injuries
- Greater autonomy and involvement in decisions about care, place of care and place of dying
- Reduced fear of dying and enhanced experience of dying for residents and their families.



### For the local NHS

- Enhanced equity in care by ensuring that care home residents are not inadvertently excluded from services which they are unable to access
- More efficient use of local resources through reduction in non-elective hospital admissions, and a proactive collaborative approach to community healthcare
- Reduction in the costs and risks of prescribing
- Improvements to safety of care by reducing harm from falls, falls-related injuries, and infections contracted while receiving medical care.

### For a sustainable care home sector

- A culture of partnership, support and shared clinical governance
- Reliable and consistent access to health professionals, including GPs
- Agreed goals of care based on proactive multidisciplinary review with residents and families
- Clarity on mutual obligations and responsibilities with regard to equipment and expertise
- Optimum access and uptake of immunisation against influenza for staff and residents
- Agreed systems of communication, including for out of hours and urgent needs.

## 3 How can these outcomes be achieved?

These outcomes can be achieved by:

- Carrying out comprehensive assessments of new residents on admission, and developing a patient-centred care plan within a specified time period
- Ensuring prompt recognition of residents requiring imminent end of life care, identifying issues and goals and making appropriate treatment plans within a shorter specified time period
- Conducting regular, structured, multi-dimensional reviews at least every six months, or sooner if clinical needs require it. These should be used to modify healthcare goals, and guide clinical interventions both in and out of hours
- Assessments to include medication review in partnership with the community or care home's pharmacist, at a frequency over and above the basic requirements of the General Medical Services contract, at least every six months. A medication review should also be completed following discharge from an acute hospital admission
- Assessment to include structured risk assessment, for example for pressure ulcers, continence and nutrition
- Creation of an advanced care plan for acute events and for preferred end of life care, in partnership with residents, their families and advocates
- Agreement of reliable systems with appropriate support tools to enable effective telephone consultation and use of out of hours referrals
- Regular scheduled visits by an appropriate GP or specialist nurse to review particular residents with new needs, perform routine reviews and to liaise with other health and social care professionals

- Clarification of referral pathways and response times for specialist input including community rehabilitation services, palliative care teams, specialist nurses (for example, regarding tissue viability), community mental health teams and geriatricians
- When and where feasible and beneficial, extending the scope of enhanced clinical interventions, for example, through the use of sub-cutaneous fluids and intravenous antibiotics according to locally agreed protocols
- Use of a robust interdisciplinary and interagency clinical governance system which promotes quality improvement and involves the care home manager and relevant staff. The system should support education and training in both core clinical skills and quality improvement methodology and encourage the development or use of clinical tools, protocols and service improvements. It should also allow for review of individual cases involving complaints and adverse incidents, as well as reviewing overall performance of the local system by regular monitoring of chosen outcome measures (see examples under Monitoring and Evaluation).



#### 4 Who should develop and provide the services?

Many services provided for care homes are relatively short-lived. It has been suggested that this is a consequence of failure to engage the care home sector in the design, development and day-to-day running of services. We would recommend that commissioners consider early involvement of local care home representatives in commissioning discussions. Evidence has shown the importance of making the most of existing relationships between health and social care providers and care home staff to broker new or enhanced care arrangements. If, for example, continence services have a specific role in care homes, their staff should then be used as advisors and collaborators to help implement broader arrangements, making the most of trusted relationships already built with the sector.

It is likely that a combination of approaches which provide residents with access to a range of specialist services, such as community geriatricians, old age psychiatrists, allied health professionals and community pharmacists will deliver the best outcomes. There is no definitive evidence which dictates whether these activities should be provided by enhanced primary care or specialist services.

Further information and examples of these services and their evaluation is available on the BGS website [www.bgs.org.uk](http://www.bgs.org.uk).

## 5 Monitoring and Evaluation

The complex nature of the needs of older people with frailty means that there is no single way in which a commissioner of health services for older people living in care homes can know if an older person is receiving optimal health care.

### However, likely indicators are:

- A defined and separately identified register of individual patients who the service provider or practice is contracted to provide services under a commissioned contract
- Evidence that individualised health care plans, and advanced care plans are in place that have been developed with patients and their families. They are being used as key documents which means that all clinicians, allied professionals and care home staff are familiar with and following them
- Reviews of health care and advanced care plans are conducted every six months as a minimum, and more often if a person's health care needs are likely to change rapidly
- Evidence that on-going and relevant training and development is taking place
- Consideration should be given to using an agreed national or international tool, such as the LPZ-i, to benchmark care across and between regions (<https://gb.lpz-um.eu/en>) - this has been used successfully in some parts of the UK
- Evidence of preventative medicine, for example % of care home residents covered by immunisation against influenza and pneumococcus (either vaccinated or been offered vaccination and declined). A target of 90% could be a useful indicator
- Improved safety of residents, for example a % reduction in the rate of fracture or reported falls
- Integrated services delivering patient-centred care: for example % of people dying in preferred place
- Evidence of reduction in residents' unplanned hospital services use, for example, % reduction in the number of Accident and Emergency attendances and non-elective hospital admissions
- Evidence of reduction in residents' use of unplanned community services: for example, % reduction in emergency ambulance use or out of hours GP call outs.



# References and resources used in this guidance

## Introduction

The number of people living in care homes in the UK, and the percentage of care home residents aged 85 or over is based on Age UK's estimation calculated from *Care of Elderly People Market Survey 2013/14*. Laing and Buisson, 2014.

### 1 Why is specialist commissioning important for older people in care homes?

The health and functional status of care home residents has been described both in a detailed cohort study with longitudinal follow-up and in large national surveys of care home providers:

Illiffe S, Davies SL, Gordon AL, Schneider J, Denning T, Bowman C, Gage H, Martin FC, Gladman RF, Victor C, Meyer G, Goodman C. *Provision of NHS generalist and specialist services to care homes in England: review of surveys*. *Prim Health Care Res Dev* 2016 17(2) 122-137.

Gordon AL, Franklin M, Bradshaw L et al. *Health status of UK care home residents: a cohort study*. *Age and Ageing* 2013 aft077–Bowman C, Whistler J, Ellerby M et al.

*A national census of care home residents*. *Age and Ageing* 2004 33:561–566.

Evidence that support from geriatricians enhances the effectiveness of interventions is shown in:

Gordon AL. *What is the case for care home medicine? The geriatrician's perspective*. *Journal of the Royal College of Physicians of Edinburgh* 2015 45(2), 148–53.

Burns E, Sherena N. *New horizons in care home medicine*. *Age and Ageing* 2014 43:2-7.

PSSRU Discussion Paper No 1675, Personal Social Services Research Unit, University of Kent at Canterbury, available online at [www.pssru.ac.uk/pdf/dp1675.pdf](http://www.pssru.ac.uk/pdf/dp1675.pdf)

The failure of existing models of healthcare to provide adequately for the complex needs of care home residents has been described both in detailed qualitative studies and in database studies which have looked at compliance with indicators on the quality outcomes framework:

Robbins I, Gordon A, Dyas J et al. *Explaining the barriers to and tensions in delivering effective healthcare in UK care homes: a qualitative study*. *BMJ open* 2013 3:e003178

Shah SM, Carey IM, Harris T et al. *Quality of chronic disease care for older people in care homes and the community in a primary care pay or performance system: retrospective study*. *BMJ* 2011 342:d912

The difficulties faced by care home residents in accessing the services provided by existing primary healthcare teams has been demonstrated in national surveys of care delivery:

Stevens CJ, Schiff R, Martin FC. *Geriatricians and care homes: perspectives from geriatric medicine departments and primary care trusts*. *ClinMed* 2009 9:528–33.

Carter C. *Failing the Frail: A Chaotic Approach to Commissioning Healthcare*.

Services for Care Homes, British Geriatrics Society available online at <http://bit.ly/17EkyBI>. A rationale for more integrated provision has been outlined in national reports and research publications:

*Quest for Quality: British Geriatrics Society Joint Working Party Inquiry into the Quality of Healthcare Support for Older People in Care Homes: A Call for Leadership, Partnership and Quality Improvement*. British Geriatrics Society 2011.

Gordon AL. University of Nottingham 2012. *Does Comprehensive Geriatric Assessment (CGA) have a role in UK Care Homes?* PhD thesis available online at <http://theses.nottingham.ac.uk/2619>.

### 2 What are the benefits of specialist commissioning?

The evidence base for intervention in care homes has usefully been reviewed across a number of articles:

Koopmans RTCM, Sideman SU, Leontjevas R et al. *Comprehensive assessment of depression and behavioural problems in long-term care*. *International psychogeriatrics / IPA* 2010 22:1054–62.

Buhr G, Whyte H. *Difficult Behaviors in Long-term Care Patients With Dementia*. *Journal of the American Medical Directors Association* 2006 7:180–192.

Ewan V, Gordon AL. *Non-respiratory infections – specific considerations in care homes*. *Reviews in Clinical Gerontology* 2010 21:78–90.

Gordon AL, Ewan V. *Pneumonia and influenza – specific considerations in care homes*. *Reviews in Clinical Gerontology* 2010 20:69.

Gordon AL, Gladman JRF. *Sleep in care homes*. *Reviews in Clinical Gerontology* 2010 20:309–316

Diabetes UK, 2014. *Diabetes in Care Homes*. [www.diabetes.org.uk/About\\_us/What-we-say/Diagnosis-ongoing-management-monitoring/Diabetes-care-for-older-people-resident-in-care-homes](http://www.diabetes.org.uk/About_us/What-we-say/Diagnosis-ongoing-management-monitoring/Diabetes-care-for-older-people-resident-in-care-homes)

The difficulty of safe prescribing and dispensing in care homes was outlined in the Care Home Use of Medications (CHUMS) study:

*Care Home Use of Medicines Study (CHUMS) Medication errors in nursing & residential care homes – prevalence, consequences, causes and solutions*. Report to the Patient Safety Research Portfolio, Department of Health. Report available online at <http://bit.ly/1akAf1o>.

There is evidence that advanced care planning and advanced directives can be successfully implemented in care homes but that they require careful exploration on a case-by-case basis.

Molloy DW, Guyatt GH, Russo R et al. *Systematic Implementation of an Advance Directive Program in Nursing Homes*. *JAMA: The Journal of the American Medical Association* 2000 283(11):1437–44

Mathie E, Goodman C, Crang C et al. *An uncertain future: the unchanging views of care home residents about living and dying*. *Palliative medicine* 2012 26:734–43.

The intensive use of primary and secondary care resources by care home residents has been documented in a number of studies and there is reason to suspect that this might be modifiable.

Gordon AL, Franklin M, Bradshaw L et al. *Health status of UK care home residents: a cohort study*. *Age and Ageing* 2013 aft 077.

D Briggs & L Bright. *Reducing hospital admissions from care homes: considering the role of a local enhanced service from GPs, Working with Older People*. March 2011 15:1,6.

Equality legislation can be viewed online at [www.legislation.gov.uk/ukpga/2010/15/contents](http://www.legislation.gov.uk/ukpga/2010/15/contents).

The importance of collaborative working with the care home sector was identified and described over a number of papers written by the APPROACH and Optimal study groups:

Goodman C, Denning T, Gordon AL, Davies SL, Meyer J, Martin FC, Gladman RF, Bowman C, Victor C, Handley M, Gage H, Illiffe S, Zubair M. *Effective health care for older people living and dying in care homes: a realist review*. *BMC Health Serv Res* 2016 16: 269.

Goodman C, Davies SL, Gordon AL, Meyer J, Denning T, Gladman JRF, Illiffe S, Zubair M, Bowman C, Victor C, Martin FC 2015. *Relationships, Expertise, Incentives, and Governance: Supporting Care Home Residents' Access to Health Care. An Interview Study From England*. *Journal of the American Medical Directors Association* 2015 16(5): 427–32.

Goodman C, Drennan V, Scheibl F et al. *Models of inter professional working for older people living at home: a survey and review of the local strategies of English health and social care statutory organisations*. *BMC Health Service Research* 2011 Dec 14 11:337.

Gage H, Dickinson A, Victor C et al. *Integrated working between residential care homes and primary care: a survey of care homes in England*. *BMC Geriatr* 2012, Nov 14, 12:71.

Davies SL, Goodman C, Bunn F et al. *A systematic review of integrated working between care homes and health care services*. *BMC Health Service Research* 2011 Nov 24, 11:320

### 3 How can these outcomes be achieved?

The use of the LPZ-I to benchmark care problems in UK care homes is described here: <http://emahsn.org.uk/psc-priority-areas/safety-in-care-homes/NICE> provides guidance on health care for older people living in care homes. [www.nice.org.uk/guidance/settings/care-homes](http://www.nice.org.uk/guidance/settings/care-homes).

In 2015 NHS England announced the first of 29 new care model vanguards which include six enhanced health in care home vanguards offering older people better, joined up health, care and rehabilitation services. Information about these is available at: [www.england.nhs.uk/ourwork/futurenhs/new-care-models/care-homes-sites/](http://www.england.nhs.uk/ourwork/futurenhs/new-care-models/care-homes-sites/)

Guidance on preventing and managing falls and fractures in care homes, NHS Education for Scotland 2016, [www.knowledge.scot.nhs.uk/fallsandbonehealth/the-national-falls-programme/management-of-falls-and-fractures-in-care-homes.aspx](http://www.knowledge.scot.nhs.uk/fallsandbonehealth/the-national-falls-programme/management-of-falls-and-fractures-in-care-homes.aspx).

*Providing nursing support within residential care homes*. Joseph Rowntree Foundation, April 2008, available online at <http://bit.ly/15ytZ>.

*Managing medicines in care homes*. NICE, March 2014 [www.nice.org.uk/guidance/sc1](http://www.nice.org.uk/guidance/sc1).

*The Right Medicine: Improving Care in Care Homes*. Royal Pharmaceutical Society, February 2016 [www.rpharms.com/promoting-pharmacy-pdfs/care-homes-report.pdf](http://www.rpharms.com/promoting-pharmacy-pdfs/care-homes-report.pdf).

*Delivering Health Ambitions: Better for Less, Care homes an enhanced primary medical service*. Yorks and the Humber NHS, 4. <http://bit.ly/16A3Dwz>.

Sandwell PCT. *Service Specification for Care Homes with Nursing Review Team*. January 2010, 7–8 <http://bit.ly/15tITXZ>.

*GP care home support 'cuts deaths and workload'*. Pulse, 15 Mar, 10 <http://bit.ly/16A5sJV>.

Cawood AL et al. *Effectiveness of implementing 'MUST' into care homes within Peterborough Primary Care Trust*. *Clinical Nutrition* 2009 4, suppl 2:81.

D Briggs & L Bright. *Reducing hospital admissions from care homes: considering the role of a local enhanced service from GPs, Working with Older People*, March 2011 15:1, 6.