

# QUICK GUIDE: CLINICAL INPUT INTO CARE HOMES

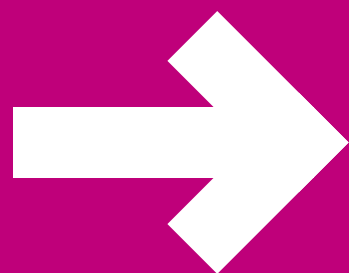
## TRANSFORMING URGENT AND EMERGENCY CARE SERVICES IN ENGLAND



This is one of a series of quick, online guides produced by NHS England with partners providing practical tips and case studies to support health and care systems.

### Click below to view

- Better use of care at home
- Identifying local care home placements
- Improving hospital discharge into the care sector
- Sharing patient information
- Technology in care homes



# INTRODUCTION

Residents in care homes often experience difficulties accessing the right care at the right time. Improving the clinical input into a home and tailoring care around the diverse needs of individual residents can improve the quality of care and quality of life for people, and reduce unnecessary hospital admissions. It is important to bear in mind that all care homes<sup>1</sup> and residents have specific needs, and residential homes have distinct needs from nursing homes.

NHS England has worked collaboratively with stakeholders across different settings to develop this Quick Guide, which comprises of case studies, ideas and practical tips on how to improve the clinical care for people living in care homes for commissioners and providers. The contents of this Quick Guide are to be taken as pragmatic recommendations to support local health and social care systems; they are not mandatory; and should be read alongside the '[Quick Guide: Identifying Local Care Home Placements](#)' and the '[Quick Guide: Technology in Care Homes](#)'.

This Quick Guide is part of longer term work to support clinical input to care homes being led by NHS England in partnership across the health and care system. Commissioners and providers may also find the British Geriatric Society's [Commissioning Guide and accompanying resources](#) of use.

## HOW TO BUILD EFFECTIVE RELATIONSHIPS

Overwhelmingly, the most important tips that stakeholders have shared on improving the clinical input into care homes are the importance of partnership working and the inclusion of care homes in planning and decision making. Effective communication will ensure the delivery of comprehensive patient care.

- 1. Local health and care systems** may wish to come together to review what additional support can be put in place in advance of this winter, using existing regulatory framework information, needs assessment, audit of care home residents and dialogue with the care homes and residents themselves. Some examples of approaches taken to understand care homes needs are [Sutton CCG](#) and [Nottingham City CCG](#), who have commissioned a 'worry-catcher' service from Age UK to review resident experience on an ongoing basis;
- 2. Commissioners** could set up care home forums to facilitate improved joint working:
  - [Vale of York CCG](#) has a care home forum with the Local Authority;
  - [Sutton CCG](#) has a bi-monthly care home forum and a care home buddying system;
  - [Frimley System Care Home Forum](#);
- 3. Health and care systems** could use training delivered to care homes as an opportunity to build stronger relationships;
- 4. Commissioners** could make an up-to-date directory of services available to care homes, for example [Vale of York CCG](#) has produced a directory of services specifically for care homes.

<sup>1</sup> For the purposes of this document, we are referring to care homes as an umbrella term for both residential homes (with no on-site nursing) and nursing homes.

# HOW TO MAKE BEST USE OF A MULTIDISCIPLINARY TEAM (MDT)

MDTs involve a range of health and care professionals, from one or more organisations, working together to deliver comprehensive patient care. The benefits of such an approach can include improved health outcomes, enhanced satisfaction for residents and a more efficient use of resources.

- MDT members** could make sure that everyone has email addresses and telephone contact details for the wider team involved in delivering care - a simple measure that has been found to be essential for achieving outcomes;
- MDT members** could make sure that information about medical care and medication is made available across all professionals caring for each resident, together with information about a resident's needs as they affect the person's health. This should be supported by training, supervision and role clarity. Find out more on record sharing [here](#); and refer to the [Quick Guide: Sharing patient information](#);
- MDT members** could look at working flexibly - not all members need to be present for the whole meeting - e.g. in North Staffordshire the geriatrician dials into the relevant part of meetings;
- Commissioners and providers** could review policies to check that they do not exclude care homes for core services - often care home residents do not receive the basic NHS support they are entitled to - see the British Geriatrics Society report [Failing the Frail](#);
- Commissioners** could consider trying new approaches - reviewing all the time to make sure it works;
- MDT members** may find the following handbooks useful: [MDT working](#), [Personalised care and support planning](#) and [Using case finding and risk stratification](#) (a key service component for personalised care and support planning).

Some examples of MDTs	Area	Reported impact
Shared management of the care and support for care home residents between GPs and community geriatricians.	Leicester	60% reduction in admission costs.
GPs, pharmacist and community psychiatrist proactively support patients through regular visits and telephone and skype links.	North Staffordshire	20% reduction in admissions and significant reduction in net mean costs per patient.
Integrated Community Ageing Team provides specialist support for care homes and a community geriatric service for the wider population- monthly MDT meetings, an in-reach service, weekly teleconferences and a telephone advice line.	Islington	26% decrease in admission and 87 less bed days per month. Improved communication and better working relationships across the community.
Three geriatricians, two advanced nurse practitioners, a GP, a nurse case manager and administrative support, providing services such as risk stratification, proactive reviews, care plans and palliative care services.	South Manchester	26% reduction admission and 68% reduction in emergency bed days.
Other examples of MDT working with care homes are <a href="#">Birmingham East and North</a> and <a href="#">South Warwickshire</a> .		

# HOW TO ENHANCE NURSING AND THERAPIES IN CARE HOMES

The role of nurses and therapists is fundamental in the planning and managing of care for residents with complex conditions. Such professionals often work at the interface of health and social care, are instrumental in co-ordinating patient care pathways following discharge from hospital, and can help to create a shift from reactive care to more proactive models of care, based on early intervention.

1. **Care homes** may wish to encourage all staff and residents to have a flu vaccination;
2. **Care homes** could consider using the College of Occupational Therapy's [Living Well Through Activity in Care Homes](#) guides;
3. **Commissioners and local NHS Trusts** could consider introducing dedicated nursing support to care homes, for example:
  - Cornwall has introduced a virtual care home team, made up of a nurse practitioner for care homes and a dementia liaison nurse, and has introduced [a whole suite of care home specific clinical management tools](#), including falls prevention, UTIs, delirium and Parkinsons;
  - [Heart of Birmingham](#) employs a nurse prescriber as a case manager to local care homes - they act as the first point of contact for care home queries, providing short term interventions and coordinating care. This has seen reductions in emergency admissions by 25%;
  - [Worcestershire](#) achieved a 23.1% reduction in A&E attendances through assigning a community nurse practitioner to specific care homes;
  - The East Sussex nurse-led rapid intervention in care homes ([ENRICH](#)) service works with care homes to improve clinical decision making to reduce avoidable admissions;
  - South Tyneside NHS Foundation Trust has established a round the clock [Gateshead Urgent Care Team](#) providing urgent, nurse-led care to care homes;
4. **Commissioners** could streamline pathways of care, for example:
  - [N&E Hertfordshire](#) has introduced a [single intermediate care pathway](#);
  - [London Ambulance Service](#) has developed a falls pathway for residents in care homes;
  - Hampshire has introduced a county-wide [post falls protocol](#);
5. **Commissioners** could ensure that care plans have been put in place for every new resident to care homes by community matrons, for example in Ashford CCG and Canterbury and Coastal CCG.

## HOW TO IMPROVE GENERAL PRACTICE INPUT TO CARE HOMES?

With multiple co-morbidities and multiple medication use, residents in care homes are often the most medically complex people in the community. According to figures from the [British Geriatrics Society](#), 68% of care home residents have no regular medical review, 44% have no regular review of medications and just 3% have occupational therapy - a critical service to promote independence. Residents need structured and pro-active approaches to their care, with coordinated teams working together built on primary care.



1. **Commissioners** could determine what constitutes an enhanced general practice service over and above the core service that is already commissioned for every resident - for example North Staffordshire used the funding formula £100 per new patient comprehensive geriatric assessment, plus £175 per resident per year, and introduced a [Locally Enhanced Service](#) that includes payment for new patient reviews, a [review](#) of people whose condition has changed significantly and post discharge visits;
2. **Commissioners and GP practices** could ensure that care home residents are receiving proactive support (such as visits for comprehensive assessment and care planning) - for example the [Care Home Assessment and Review Service](#) pilot by Wirral CCG;
3. **Commissioners and GP practices** could consider allocating one GP to each care home to provide consistency in care to residents and greater care planning, for example in [Sheffield](#) this achieved a 9% reduction in admissions;
4. **Commissioners and GP practices** could consider delivering clinics within care homes, for an example see [Suffolk](#).

## HOW TO MANAGE MEDICINES IN CARE HOMES

Residents in care homes are among the most vulnerable members of our society, reliant on care home staff for many of their everyday needs. A combination of complex medical conditions may lead to the need to take multiple medications, with care home residents taking 7-8 medications on average.

1. **Commissioners and MDTs** could ensure thorough [medication reviews of care home residents](#) occur on a regular basis. For example:
  - [NHS Aylesbury Vale and Chiltern CCG](#);
  - [Shine Project](#) in North Tyneside;
  - [Sandwell and West Birmingham Hospitals](#) have reported medication savings by implementing a Care Home Review team consisting of a consultant geriatrician, a nurse and a pharmacist;
  - [Cumbria's STOPP / START tool](#);
  - [Reviewing the use of antipsychotic drugs](#);
2. **Care homes and MDTs** could consider how they manage care home residents' medicines, for example:
  - Torbay has developed a medicines management [checklist tool](#);
  - [Sheffield](#) has commissioned specific community pharmacy advice for care homes;
  - Use of [National Care Forum resources](#) within care homes on safe use of medicines;
3. **Commissioners and care homes** could consider schemes to ensure accurate information is available on patients' medications on admission and discharge from hospital, for example South Central's [green bag scheme](#);
4. **Care homes** could introduce [calcium and vitamin D supplements](#) for residents, where clinically appropriate.
5. **Care homes and MDTs** can arrange for community pharmacies to provide flu vaccination services within care homes. Details can be found [here](#).

# HOW TO SUPPORT PEOPLE WITH DEMENTIA IN CARE HOMES

More than 80% of people living in care homes have a form of dementia or severe memory problems. According to research by the [Alzheimer's Society](#), many people with dementia are not receiving the level of person-centred care they need.

- 1. Commissioners** could put in place measures for improved diagnosis and screening of people with dementia within care homes. For example:
  - Bexley GPs have reviewed all care home residents to diagnose people with dementia;
  - In Yorkshire, [Dementia Forward](#) has been commissioned to liaise between care home managers and GPs to support dementia diagnosis and screening;
- 2. Commissioners** could consider providing specific support to nursing home staff on dementia. For example:
  - Suffolk has introduced a non-specialist [dementia advice phone line](#) which is reducing unnecessary admissions;
  - [Sussex Partnership Trust](#) has been commissioned by Surrey CCGs to provide a dementia in-reach service to care homes to reduce the use of antipsychotic drugs through non-pharmacological interventions - slowing down escalation to higher levels of care, improving quality of life of residents and reducing avoidable admissions;
  - Nottingham City CCG commissions a specialist [Dementia Outreach Team](#), which offers specialist support and training to care homes that have residents with dementia;
  - [The Centre for Assisted Technology and Connected Healthcare](#) has considered which technologies could help people with dementia within care home settings.

# HOW TO IMPROVE ORAL HEALTH, HYDRATION AND NUTRITION IN CARE HOMES

Residents in care homes need to maintain [good oral health](#), and [access to nutritious food and drinks](#).

- 1. Care homes and commissioners** could consider what they can introduce to [improve hydration and nutrition](#). For example:
  - In [Peterborough](#), a review of residents in care homes using the Malnutrition Universal Screening Tool resulted in a 27% reduction in hospital admissions and 58% reduction in the length of any hospital stays of residents;
  - Birmingham Council has developed a [urine analysis tool](#) that can be used easily by care home staff to check for dehydration in residents, particularly those with dementia who are more prone;
- 2. Care homes** could consider what they can introduce to improve the oral health of residents:
  - Ensuring that residents have access to oral hygiene products such as toothbrush and fluoride toothpaste, and denture cleaning items;
  - Supporting residents' [tooth brushing](#) regularly. This can be done using a simple chart at the bed or chair side;
  - Supporting residents with [looking after dentures](#);
  - Access to appropriate dental treatment when required and the name of their dental practice should be noted.

# HOW TO IMPROVE END OF LIFE CARE IN CARE HOMES

The median period from admission to the care home to death is 15 months, thus end of life care must be at the heart of an integrated approach to care and support for residents. [The Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020](#) contains 6 ambitions, along with building blocks to help make person centred end of life care a reality.

**1. Local health and care systems** could consider introducing initiatives which will support improved end of life care, for example:

- [Nottinghamshire](#) has introduced Electronic Palliative Care Systems (EPaCCs);
- Leicester City CCG is using the '[Deciding Right](#)' - planning your care in advance initiative to support advance care planning;
- '[Share my care](#)' is an example of an electronic system used by Ashford CCG and Canterbury and Coastal CCG care homes to share residents' care plans and wishes.

## HOW TO HARNESS TECHNOLOGY IN CARE HOMES

Technology presents an opportunity to enhance the quality of care for residents and can improve operational efficiencies; reduce risks/errors; increase capacity to manage limited resources effectively and most importantly, give health and care staff more time to deliver personalised care and support. Training and confidence in the technology being used is essential so that care home staff value the system and use it.

**Local health and care systems** could consider where technology could be introduced and carry out a costs benefits analysis of new systems. Please refer to the [Quick Guide: Technology in Care Homes](#) for examples of how technology is being used.

## HOW TO PROMOTE MENTAL HEALTH AND WELLBEING IN CARE HOMES

We know that physical activity and access to essential healthcare services are very important in the support of people's mental wellbeing. Empowering older people in care homes to be involved in all decisions about their lifestyle and care is fundamental to their [mental wellbeing](#).

**Care homes** could consider what they can put in place to support their resident's mental health and wellbeing, with some examples and useful guides below:

1. Use care homes as a community hub, particularly in rural areas;
2. [Use tools](#) to identify deterioration in wellbeing and mental state;
3. Various care homes have introduced [iPads for residents to use](#);
4. The Relatives and Residents Association has developed a number of [products](#) that can be used to promote health and wellbeing within care home;
5. The National Council for Voluntary Organisations is running a [Volunteering in Care Homes project](#), developing standards for volunteering within this specific environment.

# HOW TO SUPPORT AND UPSKILL CARE HOME STAFF

The majority of care homes residents are living with complex co-morbidities. As those residents age, their health needs inevitably increase. Upskilling and providing ongoing support for staff in clinical care can lead to a reduction in avoidable admissions and improve the quality of care provided to residents.

- 1. Local health and care systems** could include care homes in any training offers as a key partner in the system, for example the training for people with frailty to support self-care provided across [Nottinghamshire](#), and could consider delivering bespoke training to care home staff on some of the topics listed below, alongside ongoing support and advice. Any training offers should take into account the difficulties for care home staff to attend training and so a combination of e-learning and in-house training would work best;
- 2. Commissioners** may wish to identify the highest admitting care homes and provide tailored training and education for staff, for example [North West Surrey CCG](#);
- 3. Commissioners** may wish to consider putting in place protocols for 'health delegated tasks' to social care, for example Leicester, Leicestershire and Rutland has developed a [protocol](#) and [training passport](#).

Type of training	Examples of where this has been delivered to care homes
Tissue viability (pressure ulcers and wound care)	National campaign <a href="#">Your Turn</a> ; Sussex Community NHS Trust; <a href="#">React to Red Skin</a> campaign by Coventry and Rugby CCG.
Patient Group Directions (PGDs) for UTIs, chest infections, IV, catheters	Gateshead urgent care team; Sussex Community NHS Trust.
Dementia	North Central and North East London; York and Humber; Brighton and Hove CCG; <a href="#">Four Seasons PEARL project</a> .
Falls prevention	<a href="#">University Hospitals Birmingham NHS Foundation Trust</a> .
Nutrition and hydration	Sussex Community NHS Trust; North East Hampshire and Farnham CCG.
Medicines management	North West Surrey CCG.
End of life care and advance care planning	' <a href="#">Circle of Life</a> ' Board Game; St Christopher's Hospice ' <a href="#">6 Steps to Success</a> '; <a href="#">Gold Standards Framework</a> care home training.
Improving oral care	Health Education England in <a href="#">Kent Surrey and Sussex</a> .
Frailty	<a href="#">Derbyshire and Nottinghamshire</a> .
Leadership training for care home managers	<a href="#">My Home Life Transformation Package</a> .
<a href="#">Care Certificate</a>	Standards for non-regulated health and social workers.



Please sign up to the newly established Care Home Network on the **Better Care Exchange** to get involved in the next steps.

Special thanks goes to **these organisations** for their support, time, effort and commitment during the development of this Quick Guide.

Did you find this Quick Guide useful?

**Yes**

**No**

